

7553

CERTIFICATE OF DEATH

Reg. Dist. No. 17530

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halethorpe</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halethorpe</u>	
c. LENGTH OF STAY IN 1b <u>38 Yrs.</u>		d. STREET ADDRESS <u>1724 Hall Ave.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1724 Hall Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Stephen</u> Middle <u>J.</u> Last <u>Arata, Sr.</u>		4. DATE OF DEATH Month <u>July</u> Day <u>14</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 30, 1893</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gas Electric</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Louis Arata</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Raveio</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>212-05-4277</u>		17. INFORMANT <u>Stephen J Arata Jr</u> Address <u>1724 Hall Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Liver</u> 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <u>  </u> DUE TO (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>15 mo</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>59</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>
21. I certify that I attended the deceased from <u>March</u> , 19 <u>58</u> , to <u>July 14</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 13</u> , 19 <u>59</u> , and that death occurred at <u>2:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. Earl Pass</u> M.D.		ADDRESS (Street, city or town, state) <u>4001 Welbourn Ave</u> DATE SIGNED <u>7-14-59</u>	
PHYSICIAN'S NAME (Type) <u>J. EARL PASS M.D.</u>		<u>Balto 29 Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/18/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem</u>	22d. LOCATION (City, town, or county) <u>Baltimore Maryland</u> (State) <u>  </u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ambrose, Inc.</u> ADDRESS <u>1328 Sulphur Sp Rd.</u>		24a. REC'D BY REGISTRAR <u>JUL 16 '59</u> DATE	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

MEDICAL CERTIFICATION

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

7553

10-10-31

<p>1. Name of deceased</p>		<p>2. Sex</p>		<p>3. Age</p>		<p>4. Date of birth</p>	
<p>5. Place of birth</p>		<p>6. Occupation</p>		<p>7. Cause of death</p>		<p>8. Date of death</p>	
<p>9. Signature of physician</p>		<p>10. Signature of registrar</p>		<p>11. Signature of informant</p>		<p>12. Date of filing</p>	
<p>13. Name of funeral home</p>		<p>14. Address of funeral home</p>		<p>15. Name of undertaker</p>		<p>16. Address of undertaker</p>	
<p>17. Name of cemetery</p>		<p>18. Address of cemetery</p>		<p>19. Name of funeral home</p>		<p>20. Address of funeral home</p>	
<p>21. Name of undertaker</p>		<p>22. Address of undertaker</p>		<p>23. Name of funeral home</p>		<p>24. Address of funeral home</p>	
<p>25. Name of cemetery</p>		<p>26. Address of cemetery</p>		<p>27. Name of funeral home</p>		<p>28. Address of funeral home</p>	
<p>29. Name of undertaker</p>		<p>30. Address of undertaker</p>		<p>31. Name of funeral home</p>		<p>32. Address of funeral home</p>	
<p>33. Name of cemetery</p>		<p>34. Address of cemetery</p>		<p>35. Name of funeral home</p>		<p>36. Address of funeral home</p>	
<p>37. Name of undertaker</p>		<p>38. Address of undertaker</p>		<p>39. Name of funeral home</p>		<p>40. Address of funeral home</p>	
<p>41. Name of cemetery</p>		<p>42. Address of cemetery</p>		<p>43. Name of funeral home</p>		<p>44. Address of funeral home</p>	
<p>45. Name of undertaker</p>		<p>46. Address of undertaker</p>		<p>47. Name of funeral home</p>		<p>48. Address of funeral home</p>	
<p>49. Name of cemetery</p>		<p>50. Address of cemetery</p>		<p>51. Name of funeral home</p>		<p>52. Address of funeral home</p>	
<p>53. Name of undertaker</p>		<p>54. Address of undertaker</p>		<p>55. Name of funeral home</p>		<p>56. Address of funeral home</p>	
<p>57. Name of cemetery</p>		<p>58. Address of cemetery</p>		<p>59. Name of funeral home</p>		<p>60. Address of funeral home</p>	
<p>61. Name of undertaker</p>		<p>62. Address of undertaker</p>		<p>63. Name of funeral home</p>		<p>64. Address of funeral home</p>	
<p>65. Name of cemetery</p>		<p>66. Address of cemetery</p>		<p>67. Name of funeral home</p>		<p>68. Address of funeral home</p>	
<p>69. Name of undertaker</p>		<p>70. Address of undertaker</p>		<p>71. Name of funeral home</p>		<p>72. Address of funeral home</p>	
<p>73. Name of cemetery</p>		<p>74. Address of cemetery</p>		<p>75. Name of funeral home</p>		<p>76. Address of funeral home</p>	
<p>77. Name of undertaker</p>		<p>78. Address of undertaker</p>		<p>79. Name of funeral home</p>		<p>80. Address of funeral home</p>	
<p>81. Name of cemetery</p>		<p>82. Address of cemetery</p>		<p>83. Name of funeral home</p>		<p>84. Address of funeral home</p>	
<p>85. Name of undertaker</p>		<p>86. Address of undertaker</p>		<p>87. Name of funeral home</p>		<p>88. Address of funeral home</p>	
<p>89. Name of cemetery</p>		<p>90. Address of cemetery</p>		<p>91. Name of funeral home</p>		<p>92. Address of funeral home</p>	
<p>93. Name of undertaker</p>		<p>94. Address of undertaker</p>		<p>95. Name of funeral home</p>		<p>96. Address of funeral home</p>	
<p>97. Name of cemetery</p>		<p>98. Address of cemetery</p>		<p>99. Name of funeral home</p>		<p>100. Address of funeral home</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07531

## 7557 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTO. SUBURBAN</u>				c. LENGTH OF STAY IN 1b <u>2 YRS.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE SUBURBAN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4146 WILKENS AVE.</u>				d. STREET ADDRESS <u>4146 WILKENS AVE.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JACOB BAYRLE</u>				4. DATE OF DEATH Month Day Year <u>JULY 28 1959</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 9, 1875</u>			
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATCH MAN (RET.)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>SHIPS</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>									
13. FATHER'S NAME <u>GEORGE BAYRLE</u>				14. MOTHER'S MAIDEN NAME <u>GERTRUDE</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>214-26-6885</u>		17. INFORMANT <u>MRS. MILDRED MASKELL</u> Address <u>SAME</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage, natural</u> <u>572.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Disarteriosclerosis of intestines</u> <u>small and large</u> DUE TO (c) <u>5 years.</u>								INTERVAL BETWEEN ONSET AND DEATH <u>15 minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from <u>3-8</u> , 19 <u>59</u> , to <u>7-28</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>7-28</u> , 19 <u>59</u> , and that death occurred at <u>10 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>1227 Waver Blvd Baltimore 7/29/59</u>									
ACTUAL SIGNATURE <u>John P. Urlock Jr.</u> M.D.				PHYSICIAN'S NAME (Type) <u>JOHN P. URLOCK JR.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>AUG 1, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HOLY CROSS Cem</u>		22d. LOCATION (City, town, or county) (State) <u>RITCHIE Hwy A-A Co, Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Cowardson Hollins St.</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinn</u>			

CERTIFICATE OF DEATH

REG. NO. 10

DATE

DECEASED

PLACE OF BIRTH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CLERGYMAN

NAME OF CHURCH

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF WITNESS

NAME OF SIGNER

NAME OF OFFICIAL

NAME OF JUDGE

NAME OF CLERK

NAME OF RECORDER

NAME OF INDEXER

NAME OF FILED

NAME OF CLERK

NAME OF RECORDER

NAME OF INDEXER

NAME OF FILED

NAME OF CLERK

NAME OF RECORDER

NAME OF INDEXER

NAME OF FILED



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7558

CERTIFICATE OF DEATH

07532

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore Co.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 2 2</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 53</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7506 School Ave.</b>		d. STREET ADDRESS <b>7506 School Ave.</b>	
3. NAME OF DECEASED (Type or print) <b>JAMES A. BERES</b>		4. DATE OF DEATH Month Day Year <b>July 30 19 59</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/18/1909</b>
9. AGE (In years last birthday) <b>49</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supervisor (Employment) P. BR. RR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Stanley Beres</b>		14. MOTHER'S MAIDEN NAME <b>Anna Biedronski</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Irene Beres 7506 School Ave Balto. 22</b>	
17. INFORMANT <b>Irene Beres 7506 School Ave Balto. 22</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardiovascular chg</b> DUE TO (c) <b>2 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7-15</b> , 19 <b>57</b> to <b>7-30</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>7-15</b> , 19 <b>59</b> , and that death occurred at <b>4 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Jack C Collins</b>		ADDRESS (Street, city or town, state) <b>Balt 22 Md</b>	
PHYSICIAN'S NAME (Type) <b>Jack C Collins</b>		DATE SIGNED <b>7-31-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/3/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Holy Rosary Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Heber</b>		24a. REC'D BY REGISTRAR <b>401 S. Chester</b>	
24b. REGISTRAR'S SIGNATURE <b>Walter S. Kraus</b>		DATE <b>AUG 3 '59</b>	



7545

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 14 FilmG246 8-6-59 et

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>✓</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Dundalk</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Chesapeake Furn. Co.</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> 3Y01-4	
4. DATE OF DEATH <i>7-20-1959</i> Month Day Year		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>William H. Berghausen</i>		5. SEX <i>Male</i>	
6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>8-2-1907</i>		9. AGE (In years last birthday) <i>51</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>salesman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Hardware</i>	
11. BIRTHPLACE (State or foreign country) <i>Penna.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Henry Berghausen</i>		14. MOTHER'S MAIDEN NAME <i>Louisa Storr</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Lauretta Berghausen</i> Address <i>same</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CORONARY OCCLUSION</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>M. B. Davis</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>M. B. DAVIS MD</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7-21-59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Scranton, Penna.</i>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		ADDRESS <i>5305 Hargford Rd.</i>	
24a. REC'D BY REGISTRAR <i>JUL 22 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Huns</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death.

VS. A15ME  
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7559 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07534

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>City</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills, Maryland.</u>		c. LENGTH OF STAY IN 1b <u>24 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rosewood State Training School</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Maryland.</u> 3401-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rosewood State Training School</u>		d. STREET ADDRESS <u>3303 Fleet Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Zelma</u> Middle <u></u> Last <u>BETCH</u>		4. DATE OF DEATH Month <u>7</u> Day <u>6</u> Year <u>19 59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/6/25</u>
9. AGE (In years last birthday) <u>34</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-----</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John Betch (deceased)</u>	
14. MOTHER'S MAIDEN NAME <u>Annie SIMMONS (deceased)</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>Rosewood Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> DUE TO <u>Fractured left femur</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u> <u>8 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Quadruplegic (since birth); decubitus ulcer (6-months)</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell out of bed.</u>		
20c. TIME OF INJURY Month <u>6</u> Day <u>27</u> Year <u>59</u> Hour <u>11</u> a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Rosewood S.T. Schl. Owings Mills Balto.</u>	20f. (City or town) (County) (State) <u>BALTO. MD.</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>D.D. Caples</u>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>D.D. Caples, M.D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL 7-9-59</u>	22b. DATE THEREOF <u>MT. CARMEL CEM.</u>	22c. NAME OF CEMETERY OR CREMATORY <u>5712 O'DONNELL ST.</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles S. Gierls</u>		24a. REC'D BY REGISTRAR <u>9015 CONKLING ST. BALTO. 24MD</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

M

512

I

MEDICAL CERTIFICATION

03

2





TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

07535

7560

1. PLACE OF DEATH o. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COCKEYSVILLE</b>	c. LENGTH OF STAY IN 1b <b>6 MONTHS</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE 3V01-4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MASONIC HOME</b>		d. STREET ADDRESS <b>4416 OLD FREDERICK ROAD</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>KATHERINE ELIZABETH BEVANS</b>		4. DATE OF DEATH Month Day Year <b>JULY 11 1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-18-1883</b>
9. AGE (In years lost birthday) <b>75 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		13. FATHER'S NAME <b>GEORGE VOHLAND</b>	
14. MOTHER'S MAIDEN NAME <b>ELIZABETH RUHL</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>212-12-0317</b>		17. INFORMANT <b>Frank L. Smith Jr.</b> Address <b>Cockeysville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerosis cordis-vascular</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>disease</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan 16 1959</b> , to <b>July 11 1959</b> , that I last saw the deceased alive on <b>July 11 1959</b> , and that death occurred at <b>8:00</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cockeysville, Md.</b> DATE SIGNED <b>7/11/59</b>			
ACTUAL SIGNATURE <b>Elizabeth B. Sherrill</b> M.D. <b>Cockeysville, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Elizabeth B. Sherrill</b> <b>Cockeysville, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>7-15-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc., 1217 St. Paul Street</b>		24a. REC'D BY REGISTRAR <b>JUL 14 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kruus</b>



TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7561

CERTIFICATE OF DEATH

Reg. Dist. No. 07536

1. PLACE OF DEATH a. COUNTY <i>Balto.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Balto.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>52 Catonsville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>2217 Powers Lane</i>		d. STREET ADDRESS <i>2217 Powers Lane</i>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>John Henry Bebold</i>		4. DATE OF DEATH Month Day Year <i>July 4 1959</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11/13/68</i>
9. AGE (In years last birthday) yrs. <i>90</i>		10. IF UNDER 1 YEAR Months Days Hours Min. <i>90</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Shuster Cont.</i>	
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Adam Bebold</i>		14. MOTHER'S MAIDEN NAME <i>Catherine Bloom</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>John C. Bebold</i>	
17. INFORMANT <i>John C. Bebold</i>		Address <i>Catonsville</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422.1 Degenerative C. V. Disease</i> DUE TO (b) <i>Generalized Arterio Sclerosis</i> DUE TO (c) <i>15 yrs.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>6-1</i> , 19 <i>58</i> , to <i>7-4</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>7-4</i> , 19 <i>59</i> , and that death occurred at <i>10 A.</i> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>James Estowes</i>		ADDRESS (Street, city or town, state) <i>Catonsville</i>	
DATE SIGNED <i>7-5</i>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7/7/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Cathedral</i>		22d. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Don 28</i>		24a. REC'D BY REGISTRAR DATE <i>JUL 6 '59</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur E. Knud</i>			



*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]*

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06398

7562

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>42 yrs. 5mo.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Convent, 1001 W. Joppa Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Sister Mary Benigna (Bohan)</b>		4. DATE OF DEATH Month Day Year <b>July 2, 1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 16, 1871</b>
9. AGE (In years last birthday) <b>88</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nun</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Convent</b>	
11. BIRTHPLACE (State or foreign country) <b>Ireland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Cormick Bohan</b>		14. MOTHER'S MAIDEN NAME <b>Brigid Smyth</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Convent Records, 1001 W. Joppa Rd. Towson, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO <b>Hypertensive Cardio Renal</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Vascular Disease</b> DUE TO <b>10 yrs</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>14 yrs</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 6, 1948</b> , to <b>July 2, 1959</b> , that I last saw the deceased alive on <b>19</b> , and that death occurred at <b>Md.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7501 York Road Towson, Md.</b> DATE SIGNED <b>7/2/59</b>			
ACTUAL SIGNATURE <b>Charles F. O'Donnell, M.D.</b>		PHYSICIAN'S NAME (Type) <b>Charles F. O'Donnell, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/4/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Convent Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>1001 W. Joppa Rd. Towson, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lo. Vernon Gannon</b>		ADDRESS <b>4611 Park Hgts. Balto. Md.</b>	
24a. REC'D BY REGISTRAR <b>JUL 6 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frazier</b>	

## 52



Reg. Dist. No.

# CERTIFICATE OF DEATH

MEDICAL CERTIFICATION	1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> <b>3Y01-4</b>			
	d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>House in Paris 16 Fusting Ave</b>			d. STREET ADDRESS <b>Winfield 1528 Uniford Rd</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
	3. NAME OF DECEASED (Type or print) <b>Harry</b>		First <b>S</b> Middle <b>S</b> Last <b>Bird Sr</b>		4. DATE OF DEATH Month <b>7</b> Day <b>4</b> Year <b>19 59</b>			
	5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/4/1877</b>	9. AGE (In years last birthday) <b>82 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired painter</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>R.R.</b>	11. BIRTHPLACE (State or foreign country) <b>Philadepphia Pa.</b>		12. CITIZEN OF WHAT COUNTRY?	
	13. FATHER'S NAME <b>Henry S. Bird</b>				14. MOTHER'S MAIDEN NAME <b>Lena (maiden name unknown)</b>			
	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Address <b>Winfield</b> <b>Mr. Harry S. Bird Jr 1528 Uniford Rd/</b>				
	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Solar Pneumonia</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Ch. Hypertensive Cardiac-Vascular Disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>4 da.</b> <b>10 yrs (?)</b>							
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
	20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
	20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)			
	21. I certify that I attended the deceased from <b>11-3-</b> , 19 <b>55</b> , to <b>7-4-</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>7-3-</b> , 19 <b>59</b> , and that death occurred <b>at 4:59 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6209 Frederick Rd. Baltimore-25, Md.</b> DATE SIGNED <b>7-5-59</b>							
	ACTUAL SIGNATURE <b>Wilmer K. Gallager</b>		PHYSICIAN'S NAME (Type) <b>Wilmer K. Gallager</b>					
	22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	22b. DATE THEREOF <b>7/5/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Northwood Cemt.</b>		22d. LOCATION (City, town, or county) (State) <b>Phila. Pa.</b>			
	23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Ticker</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 8 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. H...</b>		

**TO HOSPITAL OR FUNERAL DIRECTOR:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7554

## CERTIFICATE OF DEATH

Reg. Dist. No.

07538

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) Md. STATE b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 7</u> X			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3610 Essex Road</u>				d. STREET ADDRESS <u>3610 Essex Rd.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>DOROTHY I. BLIZZARD</u>				4. DATE OF DEATH Month Day Year <u>July 12, 19 59</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 28, 1917</u>	9. AGE (In years lost birthday) <u>42</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>Peyton Nowlin</u>				14. MOTHER'S MAIDEN NAME <u>Pearl - (unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>			
17. INFORMANT <u>Mrs. Joan A. Keenan - 3034 Huron Ave.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CARCINOMA of CERVIX</u> DUE TO (c) <u></u>							
INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>3 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>19 56</u> , to <u>19 59</u> , that I last saw the deceased alive on <u>July 11</u> , 19 <u>59</u> , and that death occurred at <u>2 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Earle M. Wilder</u> M.D.				ADDRESS (Street, city or town, state) <u>1715 E. Howard Rd.</u>			
DATE SIGNED <u>17:11</u>							
PHYSICIAN'S NAME (Type) <u>EARLE M. WILDER, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/15/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Lickner &amp; Sons - Balto</u>				ADDRESS <u>1711</u>		24a. REC'D BY REGISTRAR <u>JUL 15 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur E. House</u>			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Signature of witness	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery	
16. Signature of health officer		17. Signature of coroner		18. Signature of jury	
19. Signature of jury		20. Signature of jury		21. Signature of jury	
22. Signature of jury		23. Signature of jury		24. Signature of jury	
25. Signature of jury		26. Signature of jury		27. Signature of jury	
28. Signature of jury		29. Signature of jury		30. Signature of jury	
31. Signature of jury		32. Signature of jury		33. Signature of jury	
34. Signature of jury		35. Signature of jury		36. Signature of jury	
37. Signature of jury		38. Signature of jury		39. Signature of jury	
40. Signature of jury		41. Signature of jury		42. Signature of jury	
43. Signature of jury		44. Signature of jury		45. Signature of jury	
46. Signature of jury		47. Signature of jury		48. Signature of jury	
49. Signature of jury		50. Signature of jury		51. Signature of jury	
52. Signature of jury		53. Signature of jury		54. Signature of jury	
55. Signature of jury		56. Signature of jury		57. Signature of jury	
58. Signature of jury		59. Signature of jury		60. Signature of jury	
61. Signature of jury		62. Signature of jury		63. Signature of jury	
64. Signature of jury		65. Signature of jury		66. Signature of jury	
67. Signature of jury		68. Signature of jury		69. Signature of jury	
70. Signature of jury		71. Signature of jury		72. Signature of jury	
73. Signature of jury		74. Signature of jury		75. Signature of jury	
76. Signature of jury		77. Signature of jury		78. Signature of jury	
79. Signature of jury		80. Signature of jury		81. Signature of jury	
82. Signature of jury		83. Signature of jury		84. Signature of jury	
85. Signature of jury		86. Signature of jury		87. Signature of jury	
88. Signature of jury		89. Signature of jury		90. Signature of jury	
91. Signature of jury		92. Signature of jury		93. Signature of jury	
94. Signature of jury		95. Signature of jury		96. Signature of jury	
97. Signature of jury		98. Signature of jury		99. Signature of jury	
100. Signature of jury		101. Signature of jury		102. Signature of jury	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7564

CERTIFICATE OF DEATH

07539

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville 28</b>		c. LENGTH OF STAY IN 1b <b>55 Towson 4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Summit Nursing Home 90 Smithwood Avenue</b>		d. STREET ADDRESS <b>6317 Bamberry Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Emma</b> Middle <b>R</b> Last <b>Bode</b>		4. DATE OF DEATH Month <b>July</b> Day <b>27</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 12, 1875</b>
9. AGE (In years last birthday) yrs. <b>84</b>		IF UNDER 1 YEAR Months <b>4</b> Days <b>27</b> Hours <b>1959</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore, Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William H. Bode</b>		14. MOTHER'S MAIDEN NAME <b>Henrietta E. Conrad</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>none</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>S. Allen Hechter, 6 Club Road, Baltimore 10</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.2</b> DUE TO <b>Congestive Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Acute &amp; chronic</b> DUE TO <b>Degenerative Heart Disease</b> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 1959</b> , to <b>7/27/59</b> , that I last saw the deceased alive on <b>7/26/59</b> , 19____, and that death occurred at <b>3:45 P.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>1303 Frederick Rd Catonsville 28md</b> DATE SIGNED <b>7/28/59</b>	
ACTUAL SIGNATURE <b>W. E. Mc Grath</b> M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type)		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-29-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Govans Presbyterian Church Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Govans 12, Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 29 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

67539

CERTIFICATE OF DEATH

7584

PLACE OF BIRTH		CITY OF BOSTON	
COUNTY		SUFFOLK	
DATE OF BIRTH		JANUARY 1, 1892	
AGE		27 YEARS	
SEX		MALE	
RACE		WHITE	
RELIGION		METHODIST	
MARRIED		YES	
WIFE'S NAME		JANE M. BROWN	
DATE OF MARRIAGE		JANUARY 1, 1915	
PLACE OF DEATH		BOSTON, MASS.	
DATE OF DEATH		JANUARY 1, 1919	
CAUSE OF DEATH		TUBERCULOSIS	
MANNER OF DEATH		NATURAL	
SIGNATURE OF DECEASED		J. M. BROWN	
SIGNATURE OF WITNESSES		J. M. BROWN	
SIGNATURE OF MINISTER		J. M. BROWN	
SIGNATURE OF CLERK		J. M. BROWN	
SIGNATURE OF JUDGE		J. M. BROWN	
SIGNATURE OF SHERIFF		J. M. BROWN	
SIGNATURE OF CORONER		J. M. BROWN	
SIGNATURE OF JURY		J. M. BROWN	
SIGNATURE OF GRAND JURY		J. M. BROWN	
SIGNATURE OF COURT		J. M. BROWN	
SIGNATURE OF STATE		J. M. BROWN	
SIGNATURE OF NATION		J. M. BROWN	
SIGNATURE OF WORLD		J. M. BROWN	
SIGNATURE OF UNIVERSE		J. M. BROWN	
SIGNATURE OF GOD		J. M. BROWN	

MASSACHUSETTS



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7565  
CERTIFICATE OF DEATH

Reg. Dist. No.

07540

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>12yr9mths</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills, Maryland</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				d. STREET ADDRESS <b>Ritters Lane</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Howard</b> Last <b>Bowen</b>				4. DATE OF DEATH Month <b>7</b> Day <b>26</b> Year <b>1959</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 13, 1883</b>	
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>John Franklin Bowen</b>				14. MOTHER'S MAIDEN NAME <b>Laura Virginia Jeffries</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypotension</b> <b>260x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Uncontrolable Diabetes</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>1946-1959</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 21</b> , 19 <b>59</b> , to <b>July 26</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>July 26</b> , 19 <b>59</b> , and that death occurred at <b>7:00 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>7/26/59</b> ACTUAL SIGNATURE <b>Bruno Radauskas</b> M.D. PHYSICIAN'S NAME (Type) <b>BRUNO RADAUSKAS</b> <b>Catonsville 28, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 28/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>		22d. LOCATION (City, town, or county) (State) <b>Pikesville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.F.Eline &amp; Sons, Reisterstown, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 28 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

01320

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

CERTIFICATE OF DEATH

762

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		MALE		35		JAN 5 1928		MOBILE, ALABAMA	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		RACE	
COUNSELOR		HIGH SCHOOL		MARRIED		METHODIST		WHITE	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.	
JAN 30 1968		MEMPHIS, TENNESSEE		HEART DISEASE		SUICIDE		762	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF DEATH REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN 31 1968		JAN 31 1968		JAN 31 1968		JAN 31 1968		JAN 31 1968	

RECEIVED  
JAN 31 1968  
BALTIMORE, MD

RECEIVED  
JAN 31 1968  
BALTIMORE, MD

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7566

## CERTIFICATE OF DEATH

Reg. Dist. No. 07541

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore, Maryland</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Maryland</u> <u>3Y01-4</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Stella Maris Hospice—Towson—4 Md.</u>				d. STREET ADDRESS <u>5607 Gardenville Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Lydia</u> Middle <u>Braker</u> Last <u>Braker</u>				4. DATE OF DEATH Month <u>7</u> Day <u>25</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/10/1886</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months <u>72</u> Days <u>10</u> Hours <u>10</u> Min.		11. BIRTHPLACE (State or foreign country) <u>Aberdeen, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>			
13. FATHER'S NAME <u>Richard Cullum</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Preston</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>None</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Tubercular pneumonia</u> <u>522x</u> DUE TO (b) <u>Uremia</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) <u>Uremia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>15 hours</u> <u>10 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I as Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>March 1, 1959</u> to <u>July 25, 1959</u> , that I last saw the deceased alive on <u>July 25, 1959</u> , and that death occurred at <u>4:20 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles F. O'Donnell, M.D.</u>				ADDRESS (Street, city or town, state) <u>2501 York Rd. Towson 4 Md.</u>			
PHYSICIAN'S NAME (Type) <u>Charles F. O'Donnell—M.D.</u>				DATE SIGNED <u>7/25/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>7-28-59</u>				22b. DATE THEREOF			
22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore</u>				22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lemuel J. Buck</u>				ADDRESS <u>5305 Bayford</u>			
24a. REC'D BY REGISTRAR <u>DATE JUL 28 '59</u>				24b. REGISTRAR'S SIGNATURE <u>Charles E. Kneass</u>			

STATE BOARD OF HEALTH

DECEMBER 1918

CERTIFICATE OF DEATH

NEW YORK AND STATE DEPARTMENT OF HEALTH - BATHING, 18

1918

1918

DECEASED

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

OCCUPATION

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

RELIGION

MARRIAGE

CHILDREN

PREVIOUS ILLNESS

DIAGNOSIS

TREATMENT

POST-MORTEM

INTERVIEW

SIGNATURE

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7567 CERTIFICATE OF DEATH

07542

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>6yr27dys</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3V01-4</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				d. STREET ADDRESS <u>100 Burnett Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Branigan</u> Last <u>Branigan</u>				4. DATE OF DEATH Month <u>July</u> Day <u>27</u> Year <u>19 59</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>separated</u> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 3, 1885</u>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min.	IF UNDER 24 HRS. Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>domestic</u>		11. BIRTHPLACE (State or foreign country) <u>(Unknown) Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>(Unknown) U.S.A.</u>	
13. FATHER'S NAME <u>(Unknown) Joseph Branigan</u>				14. MOTHER'S MAIDEN NAME <u>Unknown (Mary)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>212-12-9310</u>		17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u> INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 6</u> , 19 <u>59</u> , to <u>July 27</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 27</u> , 19 <u>59</u> , and that death occurred at <u>10:00p</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stella Wachslar</u>				ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u>			
PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>				DATE SIGNED <u>7-28-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JULY 30, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>		22d. ADDRESS (Street, city or town, state) <u>Old Frederick Road Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>FLYNN &amp; FLEMING, INC.</u>				ADDRESS <u>1422 Light St. Baltimore, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 30 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur E. ...</u>			





7568

## CERTIFICATE OF DEATH

07543

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Towson</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rural Towson</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Glenarm Road</u>				d. STREET ADDRESS <u>Glenarm Road</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sister Mary Trinidad Brazaitis</u>				4. DATE OF DEATH Month Day Year <u>July 20 1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 22, 1885</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Jacksons, Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Joseph Brazaitis</u>				14. MOTHER'S MAIDEN NAME <u>Ursula Mutzeianski</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Sr. M. Peter Fourier</u>	
				Address <u>Notbth Cliff, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardio-renal disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>10 yrs.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) <u>Towson, Md.</u>		(County) (State)	
21. I certify that I attended the deceased from <u>July 1953</u> , to <u>July 1959</u> , that I last saw the deceased alive on <u>June 23, 1959</u> , and that death occurred at <u>9.55 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7501 York Road Towson, Md.</u> DATE SIGNED <u>7/20/59</u>							
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Charles F. O'Donnell M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>7-22-59</u>		<u>VILLA MARIA CEM.</u>		<u>NOTCH CLIFF NATONAL, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Julius T. Home Bldg. 24 Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 7569 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riderwood</b>		c. LENGTH OF STAY IN 1b <b>301-4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ruxway Manor</b>		d. STREET ADDRESS <b>5118 Whiteford Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>Elizabeth</b> Middle <b>Barbara</b> Last <b>Brickman</b>		4. DATE OF DEATH Month <b>July</b> Day <b>23</b> Year <b>1959</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 28, 1866</b>
9. AGE (In years last birthday) yrs. <b>92</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>George A. Keller</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Nugent</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>***</b>	
17. INFORMANT <b>M. Isabelle Keller</b>		Address <b>Above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRO VASCULAR HEMORRHAGE</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROSIS, GENERALIZED</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>4 DAYS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10/26</b> , 19 <b>57</b> , to <b>7/23</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>7/22</b> , 19 <b>59</b> , and that death occurred at <b>10:40</b> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>T. C. Siwinski</b>		ADDRESS (Street, city or town, state) <b>17 W. PENNA. AVE</b>	
PHYSICIAN'S NAME (Type) <b>T.C. SIWINSKI</b>		DATE SIGNED <b>7/24/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-25-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H.W. Jenkins &amp; Sons Co.</b>		ADDRESS <b>4905 York Rd.</b>	
24a. REC'D BY REGISTRAR <b>JUL 24 '59</b>		24b. REGISTRAR'S SIGNATURE <b>William A. Thomas</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

DATE OF DEATH

<p>1. Name of deceased</p>		<p>2. Sex</p>	
<p>3. Age</p>		<p>4. Date of birth</p>	
<p>5. Place of birth</p>		<p>6. Usual residence</p>	
<p>7. Cause of death</p>		<p>8. Date of death</p>	
<p>9. Place of death</p>		<p>10. Signature of physician</p>	
<p>11. Signature of registrar</p>		<p>12. Signature of informant</p>	
<p>13. Signature of medical examiner</p>		<p>14. Signature of coroner</p>	
<p>15. Signature of funeral director</p>		<p>16. Signature of undertaker</p>	
<p>17. Signature of cemetery</p>		<p>18. Signature of burial</p>	
<p>19. Signature of interment</p>		<p>20. Signature of cremation</p>	
<p>21. Signature of disposition</p>		<p>22. Signature of other</p>	
<p>23. Signature of witness</p>		<p>24. Signature of other</p>	
<p>25. Signature of other</p>		<p>26. Signature of other</p>	
<p>27. Signature of other</p>		<p>28. Signature of other</p>	
<p>29. Signature of other</p>		<p>30. Signature of other</p>	
<p>31. Signature of other</p>		<p>32. Signature of other</p>	
<p>33. Signature of other</p>		<p>34. Signature of other</p>	
<p>35. Signature of other</p>		<p>36. Signature of other</p>	
<p>37. Signature of other</p>		<p>38. Signature of other</p>	
<p>39. Signature of other</p>		<p>40. Signature of other</p>	
<p>41. Signature of other</p>		<p>42. Signature of other</p>	
<p>43. Signature of other</p>		<p>44. Signature of other</p>	
<p>45. Signature of other</p>		<p>46. Signature of other</p>	
<p>47. Signature of other</p>		<p>48. Signature of other</p>	
<p>49. Signature of other</p>		<p>50. Signature of other</p>	
<p>51. Signature of other</p>		<p>52. Signature of other</p>	
<p>53. Signature of other</p>		<p>54. Signature of other</p>	
<p>55. Signature of other</p>		<p>56. Signature of other</p>	
<p>57. Signature of other</p>		<p>58. Signature of other</p>	
<p>59. Signature of other</p>		<p>60. Signature of other</p>	
<p>61. Signature of other</p>		<p>62. Signature of other</p>	
<p>63. Signature of other</p>		<p>64. Signature of other</p>	
<p>65. Signature of other</p>		<p>66. Signature of other</p>	
<p>67. Signature of other</p>		<p>68. Signature of other</p>	
<p>69. Signature of other</p>		<p>70. Signature of other</p>	
<p>71. Signature of other</p>		<p>72. Signature of other</p>	
<p>73. Signature of other</p>		<p>74. Signature of other</p>	
<p>75. Signature of other</p>		<p>76. Signature of other</p>	
<p>77. Signature of other</p>		<p>78. Signature of other</p>	
<p>79. Signature of other</p>		<p>80. Signature of other</p>	
<p>81. Signature of other</p>		<p>82. Signature of other</p>	
<p>83. Signature of other</p>		<p>84. Signature of other</p>	
<p>85. Signature of other</p>		<p>86. Signature of other</p>	
<p>87. Signature of other</p>		<p>88. Signature of other</p>	
<p>89. Signature of other</p>		<p>90. Signature of other</p>	
<p>91. Signature of other</p>		<p>92. Signature of other</p>	
<p>93. Signature of other</p>		<p>94. Signature of other</p>	
<p>95. Signature of other</p>		<p>96. Signature of other</p>	
<p>97. Signature of other</p>		<p>98. Signature of other</p>	
<p>99. Signature of other</p>		<p>100. Signature of other</p>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If any delay is necessary, please excuse the certificate from the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
7570 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Reg. Dist. No. 07545											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Port Howard</b>				c. LENGTH OF STAY IN 1b <b>24 days</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> <b>3Y01-4</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>3704 Dennlyn Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>IVAN</b> Middle <b>L.</b> Last <b>BRIGGS</b>				4. DATE OF DEATH Month <b>July</b> Day <b>31</b> Year <b>1959</b>							
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 19, 1907</b>		9. AGE (In years last birthday) <b>51 yrs.</b>		IF UNDER 1 YEAR Months <b>51</b> Days <b>31</b> Hours <b>1959</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Library Clerk</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Social Security</b>		11. BIRTHPLACE (State or foreign country) <b>Cumberland, Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Briggs</b>						14. MOTHER'S MAIDEN NAME <b>Olivia Smith</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>WW II</b>				16. SOCIAL SECURITY NO. <b>217-05-6589</b>		17. INFORMANT <b>Clin. Records, VA Hosp., Ft. Howard, Md.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>442X</b> DUE TO <b>Pulmonary Edema due to Hypertensive and Arteriosclerotic Renal Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Multiple Fractures of Lower Extremities</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>Fell out of 3rd floor window</b>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell out of 3rd floor window</b>							
20c. TIME OF INJURY Hour <b>9:30</b> AM <b>7/17/59</b> p. m. Month, Day, Year				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hospital</b>		20f. (City or town) <b>Ft. Howard Hosp. Baltimore Md.</b>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Charles S. Petty</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <b>8/2/59</b>			
EXAMINER'S NAME (Type) <b>Charles S. Petty</b>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug 4, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>				22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arlington S. Phillips</b>						ADDRESS <b>1808 N. Mondoe St.</b>		24a. REC'D BY REGISTRAR <b>DATE AUG 3 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraw</b>	

01235

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12		TO THE MEDICAL EXAMINER'S CERTIFICATE OF DEATH	
1. Name of Deceased		2. Sex	
3. Age		4. Date of Birth	
5. Place of Birth		6. Occupation	
7. Usual Residence		8. Date of Death	
9. Cause of Death		10. Manner of Death	
11. Signature of Medical Examiner		12. Signature of Coroner	
13. Signature of Registrar		14. Signature of Burial Officer	
15. Signature of Undertaker		16. Signature of Funeral Home	
17. Signature of Cemetery		18. Signature of Burial Place	
19. Signature of Burial Officer		20. Signature of Burial Place	
21. Signature of Burial Officer		22. Signature of Burial Place	
23. Signature of Burial Officer		24. Signature of Burial Place	
25. Signature of Burial Officer		26. Signature of Burial Place	
27. Signature of Burial Officer		28. Signature of Burial Place	
29. Signature of Burial Officer		30. Signature of Burial Place	
31. Signature of Burial Officer		32. Signature of Burial Place	
33. Signature of Burial Officer		34. Signature of Burial Place	
35. Signature of Burial Officer		36. Signature of Burial Place	
37. Signature of Burial Officer		38. Signature of Burial Place	
39. Signature of Burial Officer		40. Signature of Burial Place	
41. Signature of Burial Officer		42. Signature of Burial Place	
43. Signature of Burial Officer		44. Signature of Burial Place	
45. Signature of Burial Officer		46. Signature of Burial Place	
47. Signature of Burial Officer		48. Signature of Burial Place	
49. Signature of Burial Officer		50. Signature of Burial Place	
51. Signature of Burial Officer		52. Signature of Burial Place	
53. Signature of Burial Officer		54. Signature of Burial Place	
55. Signature of Burial Officer		56. Signature of Burial Place	
57. Signature of Burial Officer		58. Signature of Burial Place	
59. Signature of Burial Officer		60. Signature of Burial Place	
61. Signature of Burial Officer		62. Signature of Burial Place	
63. Signature of Burial Officer		64. Signature of Burial Place	
65. Signature of Burial Officer		66. Signature of Burial Place	
67. Signature of Burial Officer		68. Signature of Burial Place	
69. Signature of Burial Officer		70. Signature of Burial Place	
71. Signature of Burial Officer		72. Signature of Burial Place	
73. Signature of Burial Officer		74. Signature of Burial Place	
75. Signature of Burial Officer		76. Signature of Burial Place	
77. Signature of Burial Officer		78. Signature of Burial Place	
79. Signature of Burial Officer		80. Signature of Burial Place	
81. Signature of Burial Officer		82. Signature of Burial Place	
83. Signature of Burial Officer		84. Signature of Burial Place	
85. Signature of Burial Officer		86. Signature of Burial Place	
87. Signature of Burial Officer		88. Signature of Burial Place	
89. Signature of Burial Officer		90. Signature of Burial Place	
91. Signature of Burial Officer		92. Signature of Burial Place	
93. Signature of Burial Officer		94. Signature of Burial Place	
95. Signature of Burial Officer		96. Signature of Burial Place	
97. Signature of Burial Officer		98. Signature of Burial Place	
99. Signature of Burial Officer		100. Signature of Burial Place	

11-11



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7571

CERTIFICATE OF DEATH

07546

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Ba7to</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>		d. STREET ADDRESS <b>12607 Sparrows Pt. Rd</b>	
3. NAME OF DECEASED (Type or print) <b>Issac Taylor Brooks</b>		4. DATE OF DEATH Month <b>7</b> Day <b>7</b> Year <b>1959</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/3/1897</b>
9. AGE (In years last birthday) <b>61</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffeur</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Walter Brooks</b>		14. MOTHER'S MAIDEN NAME <b>Martha Wheeler</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>228-10-1730</b>	
17. INFORMANT <b>Hospital Records, Mt. Wilson State Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>For Advanced Pulmonary Tuberculosis</b> DUE TO (b) <b>18 yrs</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>002X</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12/26</b> , 19 <b>58</b> , to <b>7/7</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>7/7</b> , 19 <b>59</b> , and that death occurred at <b>6:40 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Mt. Wilson, Maryland</b> DATE SIGNED			
ACTUAL SIGNATURE <b>William Newcomer</b> M.D.		PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b> Superintendent	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>July 7, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Family Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Spotsylvania Co., Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frank H. Newell, Pikesville Md.</b> ADDRESS		24a. REC'D BY REGISTRAR <b>JUL 10 '59</b> DATE	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			



TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove organ papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7572

## CERTIFICATE OF DEATH

Reg. Dist. No.

07547

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Forest Haven Nurs.Ho.315 Ingleside Ave</b>		d. STREET ADDRESS <b>1239 Greystone Rd.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>S.</b> Last <b>BROWN</b>		4. DATE OF DEATH Month <b>July</b> Day <b>26,</b> Year <b>1959</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 10, 1899</b>
9. AGE (In years last birthday) <b>60</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>male nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>George Brown</b>		14. MOTHER'S MAIDEN NAME <b>Margaret -</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>World War I</b>	
17. INFORMANT <b>Mrs. Dorothy Thomas-1239 Greystone Rd., Arbutus</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MASSIVE CEREBRAL HEMORRHAGE</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIO-SCLEROTIC HEART</b> DUE TO (c) <b>URSCULAR DISEASE - DIABETES</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7/1</b> , 19 <b>59</b> , to <b>7/26</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>7/25</b> , 19 <b>59</b> , and that death occurred at <b>11 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>John H. Show</b> M.D. <b>5800 Edmonson Ave 7/28/59</b> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <b>John H. Show MD</b> <b>AD 45-78, 114</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/29/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Sicker Y. Sover - Baltto 17</b>		24a. REG'D BY REGISTRAR DATE <b>JUL 29 59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>			



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7573

## CERTIFICATE OF DEATH

Reg. Dist. No.

07548

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>23 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> 3v01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>707 West Lanvale Street (17)</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JEROME</b> Middle <b>F.</b> Last <b>BROWN</b>				4. DATE OF DEATH Month <b>July</b> Day <b>5</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>January 14, 1909</b> 50	
9. AGE (In years last birthday) yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic - Automobile</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Jesse Brown</b>				14. MOTHER'S MAIDEN NAME <b>Eva Roberts</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW II 216-05-2299</b>		17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF ESOPHAGUS WITH METASTASIS</b> 150X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET OF DEATH <b>UNKNOWN</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 12</b> , 19 <b>59</b> , to <b>July 5</b> , 19 <b>59</b> , that I last saw the deceased <b>alive on June 12, 1959</b> , and that death occurred at <b>8:30P</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John W. Crawford</b>				M.D. <b>VAH, FORT HOWARD, MARYLAND</b>		DATE SIGNED <b>7/6/59</b>	
PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b>				<b>VAH, FORT HOWARD, MARYLAND</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-10/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cathedral Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Earl Gilmore Funeral Home</b>				ADDRESS <b>519 Mosher Street Baltimore, Md.</b>		24a. REC'D BY REGISTRAR <b>JUL 10 1959</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>	





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the cause of the delay in writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director, and Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

7555 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07549

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halethorpe</u>		c. LENGTH OF STAY IN 1b <u>52</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5715 South Western Blvd</u>		d. STREET ADDRESS <u>815 Hill Top Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Joseph A C Browne</u>		4. DATE OF DEATH <u>July 3, 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 27 1912</u>
9. AGE (In years last birthday) <u>46</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>President Building Supply</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Building Supply</u>	
11c. BIRTHPLACE (State or foreign country) <u>Penn</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Albert Browne</u>		14. MOTHER'S MAIDEN NAME <u>Eva Chatter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>217 24 6847</u>	
17. INFORMANT <u>Mrs Helen K Browne</u>		Address <u>815 Hill Top Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Killed by being crushed by load of lumber</u> 910.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>slipping off machine</u> DUE TO (c) <u>Head and body badly crushed, Accident</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Load of lumber slipped from machine falling on man</u>	
20c. TIME OF INJURY Month, Day, Year <u>5 P.m. July 3, 59</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Factory</u>		20f. (City or town) <u>Halethorpe</u> (County) <u>Balto.</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Geo S M Kieffer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Geo. S. M. Kieffer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/6/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Mem. Pk.</u>		22d. LOCATION (City, town, or county) (State) <u>Elkridge, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Lickner &amp; Sons - Balto</u>		24a. REC'D BY REGISTRAR <u>DATE JUL 8 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>	

11-1-58

STATE OF CALIFORNIA  
DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF DEATH		6. TIME OF DEATH		7. PLACE OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. SIGNATURE OF EXAMINER		11. SIGNATURE OF WITNESS		12. SIGNATURE OF JURY	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7574

## CERTIFICATE OF DEATH

Reg. Dist. No.

07550

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sparrows Point</b>		c. LENGTH OF STAY IN 1b <b>34 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1127 "H" Street</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sparrows Point (19)</b>	
3. NAME OF DECEASED (Type or print) First <b>HERMAN</b> Middle <b>+++</b> Last <b>BYROADE</b>		4. DATE OF DEATH Month <b>July</b> Day <b>14th</b> Year <b>1959</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 31, 1925</b>
9. AGE (In years last birthday) <b>34</b> yrs.		IF UNDER 1 YEAR Months <b>34</b> Days <b>34</b> Hours <b>34</b> Min. <b>34</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dye Maker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Dean W. Byroade</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Moore</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>216-28-9945</b>	
17. INFORMANT <b>D.W. Byroade</b>		Address <b>same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>DUE TO</b> (c) <b>DUE TO</b>		INTERVAL BETWEEN ONSET AND DEATH <b>---</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1, 1959</b> to <b>July 14, 1959</b> that I last saw the deceased alive on <b>July 14, 1959</b> and that death occurred at <b>1:00 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>R G WINDSOR</b>		M.D. <b>5200 St, Balt 19</b>	
PHYSICIAN'S NAME (Type) <b>R G WINDSOR</b>		DATE SIGNED <b>7.15</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 18, 59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Co., Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Brooks Bradley, Inc., Dundalk 22, Md</b>		24a. REC'D BY REGISTRAR <b>JUL 20 '59</b>	
ADDRESS <b>Walter Brooks Bradley, Inc., Dundalk 22, Md</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hous</b>	



Item 7, Film G245, 7/24/59  
**7575**  
**CERTIFICATE OF DEATH**

Reg. Dist. No. **07551**

1. PLACE OF DEATH a. COUNTY <b>Roger Carter Balto., Co. MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>34 Winters Lane</b>				d. STREET ADDRESS <b>34 Winters Lane</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Roger Carter</b> First Middle Last				4. DATE OF DEATH <b>July 13,</b> Month Day Year <b>59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/1/37</b>	
9. AGE (In years last birthday) <b>21</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Roger Carter</b>				14. MOTHER'S MAIDEN NAME <b>Dora Hopkins</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Margaret Hopkins 34 Winters Lane</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Status Epilepticus</b> <b>353.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Epilepsy (Grand Mal) Several years</b> DUE TO (c) <b>(Grand Mal)</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>July 6th, 1959</b> , to <b>July 13, 1959</b> , that I last saw the deceased alive on <b>July 13, 1959</b> , and that death occurred at <b>3.00 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>C. F. Maloney</b>				ADDRESS (Street, city or town, state) <b>57 Winters Lane, Balto.</b>			
PHYSICIAN'S NAME (Type) <b>C. F. Maloney, M.D.</b>				DATE SIGNED <b>7/13/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/16/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Carver Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Murkirk, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles A. Rice</b>				ADDRESS <b>661 W. Barre Street</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 20 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Charles B. Kraus</b>			

TAM BOND

CERTIFICATE OF DEATH

01551

Name of deceased		Date of death	
Place of death		Cause of death	
Age of deceased		Sex of deceased	
Occupation of deceased		Marital status of deceased	
Signature of physician		Signature of registrar	
Signature of medical examiner		Signature of coroner	
Signature of funeral director		Signature of undertaker	
Signature of cemetery		Signature of burial place	
Signature of family		Signature of friends	
Signature of neighbors		Signature of community	
Signature of church		Signature of school	
Signature of other		Signature of other	



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08753

7576

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>10 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u> <u>16-14-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				d. STREET ADDRESS <u>8902 Baltimore Boulevard</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Eugene</u> First <u>Casey</u> Middle <u>Casey</u> Last				4. DATE OF DEATH Month <u>July</u> Day <u>20</u> Year <u>1959</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Unknown</u>	
9. AGE (In years last birthday) <u>45?</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		11. BIRTHPLACE (State or foreign country) <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>Unknown</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>			
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cirrhosis of liver</u> <u>581.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>  </u> o. m. <u>  </u> p. m. <u>  </u> Month <u>  </u> Day <u>  </u> Year <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>June 27</u> , 19 <u>59</u> , to <u>July 20</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 20</u> , 19 <u>59</u> , and that death occurred at <u>5:30p</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stella Wachslar</u>				DATE SIGNED <u>7-22-59</u>			
PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>				<u>Catonsville 28k Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>8/15/59</u>		<u>Cathedral</u>		<u>4300 Oak Indemnity</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Foley &amp; Sons</u>				ADDRESS <u>1318 Light</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 17 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>C. L. S. Kraus</u>							



7577

CERTIFICATE OF DEATH

07552

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Ma.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. LENGTH OF STAY IN 1b <u>55</u> <u>Towson</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8344 Ridgeley Oak Rd.</u>				d. STREET ADDRESS <u>1 8344 Ridgeley Oak Rd.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Grace</u> Middle <u>A.</u> Last <u>Cockerill</u>				4. DATE OF DEATH Month <u>July</u> Day <u>31</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-17-1919</u>	
9. AGE (In years last birthday) <u>40</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Frederick Ackerman</u>				14. MOTHER'S MAIDEN NAME <u>Lillian Hinkle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>  </u>		INFORMANT <u>James J. Cockerill</u> Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>170x Uremia</u> DUE TO <u>Carcinomatosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO <u>Bilateral Breast Cancer</u> (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>1 yr.</u> <u>4 yrs.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. (City or town) <u>  </u>				20g. (County) <u>  </u>		20h. (State) <u>  </u>	
21. I certify that I attended the deceased from <u>July 31, 1959</u> to <u>July 31, 1959</u> , that I lost s/he the deceased olive on <u>July 31, 1959</u> , and that death occurred at <u>7:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph F. Hinkle</u> M.D.				ADDRESS (Street, city or town, state) <u>8400 Rock Haven Rd. Baltimore, Md</u>			
DATE SIGNED <u>7-31-59</u>							
PHYSICIAN'S NAME (Type) <u>JOSEPH F. HINKLE M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/3/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PARKWOOD</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>				ADDRESS <u>5305 Harford Rd.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 3 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

01528

OFFICE OF THE

7577

1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7578 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07553

Items 5, 8 Film G246 8-10-59 et

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk (22)</b>		c. LENGTH OF STAY IN 1b <b>3 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>53 Dundalk (22)</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>6725 Thruway</b>				d. STREET ADDRESS <b>6725 Thruway</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Warren</b> Middle <b>WILLIAM</b> Last <b>COLEMAN</b>				4. DATE OF DEATH Month <b>July</b> Day <b>31st</b> , Year <b>1959</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 4, 1915</b>		9. AGE (In years last birthday) <b>43</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Checker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>		11. BIRTHPLACE (State or foreign country) <b>Danville, Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Coleman</b>				14. MOTHER'S MAIDEN NAME <b>Hannah ???</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>202-09-7677</b>		17. INFORMANT <b>Ella S. Coleman</b>		Address <b>same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO <b>Arteriosclerotic H.D.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <b>6 mos</b> <b>2 yrs</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Jack C. Collins</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>8/1/59</b>	
EXAMINER'S NAME (Type) <b>Jack C. Collins, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/4/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Co., Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Brooks Bradley, Inc.</b>				ADDRESS <b>Dundalk 22</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 3 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please see instructions on the reverse side. Write the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7579

## CERTIFICATE OF DEATH

Reg. Dist. No.

07554

1. PLACE OF DEATH a. COUNTY <u>Baltimore - 19</u> - MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ft. Howard</u>		c. LENGTH OF STAY IN 1b <u>33 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Avenue B</u>		d. STREET ADDRESS <u># 1</u>	
3. NAME OF DECEASED (Type or print) <u>JOHN THOMAS CONNOR</u>		4. DATE OF DEATH Month <u>July</u> Day <u>16</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 16 1885</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Press operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>215-07-0141</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Connor</u>		14. MOTHER'S MAIDEN NAME <u>Ida Mills</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>215-07-0141</u>	
17. INFORMANT <u>Lillian Connor (wife)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardio Vascular disease</u> DUE TO (c) <u>7 years</u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 23</u> , 19 <u>59</u> to <u>July 16</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 1</u> , 19 <u>59</u> , and that death occurred at <u>8 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Louise N. Tollin</u>		ADDRESS (Street, city or town, state) <u>6908 N. POINT RD. BALTO - 19 - MD</u>	
DATE SIGNED <u>7/16/59</u>			
PHYSICIAN'S NAME (Type) <u>LOUISE N. TOLLIN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/20/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Belair Memorial Gardens</u>		22d. LOCATION (City, town, or county) (State) <u>Belair, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ullrich Funeral Home 2112 Dundalk Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 20 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>			

CERTIFICATE OF DEATH

1934

01234

THE STATE OF MARYLAND

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15 1889</i>		5. PLACE OF BIRTH <i>Baltimore, Md</i>		6. OCCUPATION <i>Teacher</i>	
7. MARITAL STATUS <i>Married</i>		8. COLOR <i>White</i>		9. RELIGION <i>Methodist</i>		10. EDUCATION <i>High School</i>		11. SOCIAL STATUS <i>Working</i>		12. PLACE OF DEATH <i>Home</i>	
13. CAUSE OF DEATH <i>Heart Disease</i>		14. DISEASE OR INJURY <i>Myocardial Infarction</i>		15. PERIOD OF ILLNESS <i>2 weeks</i>		16. TIME OF DEATH <i>10:30 AM</i>		17. DAY OF DEATH <i>Jan 20</i>		18. YEAR OF DEATH <i>1934</i>	
19. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>		20. SIGNATURE OF WITNESS <i>John Doe</i>		21. SIGNATURE OF DECEASED <i>John Doe</i>		22. SIGNATURE OF FUNERAL HOME <i>John Doe</i>		23. SIGNATURE OF BURIAL PLACE <i>John Doe</i>		24. SIGNATURE OF OTHER <i>John Doe</i>	



RECEIVED  
JAN 21 1934  
BALTIMORE, MD

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7580

CERTIFICATE OF DEATH

Reg. Dist. No.

07555

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> 3401-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Foxleigh Nursing Home</i>		d. STREET ADDRESS <i>3200 Labyrinth Rd</i>	
3. NAME OF DECEASED (Type or print) <i>Bessie</i> First <i>Cooper</i> Middle Last		4. DATE OF DEATH <i>7-10-1959</i> Month Day Year	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-7</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Baltimore Md</i>
13. FATHER'S NAME <i>Isaac Caplan</i>		14. MOTHER'S MAIDEN NAME <i>Not Known</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>INFORMANT</i> Address <i>Henry Robinson - Same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>163X Carcinoma of lung with metastases</i> DUE TO (b) <i>1 year</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>7/8</i> , 19 <i>59</i> , to <i>present</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>7/8</i> , 19 <i>59</i> , and that death occurred at <i>4 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Bernard Burgin</i>		ADDRESS (Street, city or town, state) <i>6721 Reisterstown Rd Balto Md</i> DATE SIGNED <i>7/10/59</i>	
PHYSICIAN'S NAME (Type) <i>BERNARD BURGIN</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7-12-59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Baltimore Hebrew</i>		22d. LOCATION (City, town, or county) (State) <i>Balto Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Jack Levin Inc</i> ADDRESS <i>2100 Eutan Place</i>		24a. REC'D BY REGISTRAR DATE <i>JUL 14 '59</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Harris</i>	

01558

LIBRARY OF CONGRESS

17520

17520



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7581

## CERTIFICATE OF DEATH

07556

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>1yr18mth13dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>1200 Carroll Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Wallace</b> Last <b>Covington</b>		4. DATE OF DEATH Month <b>July</b> Day <b>29</b> Year <b>1959</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 28, 1905</b>
9. AGE (In years last birthday) <b>54</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>tool and die maker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Revere Copper</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William Covington</b>		14. MOTHER'S MAIDEN NAME <b>Helen Wallace</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>C-3-458-684</b>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <b>218-05-7618</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>Generalized arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 15</b> , 19 <b>57</b> , to <b>July 29</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>July 29</b> , 19 <b>59</b> , and that death occurred at <b>9:40a</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stella Wachslar</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>SPRING GROVE STATE HOSPITAL 7-29-59</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>		<b>Catonsville 28, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>7-31-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 31 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Brown</b>	





TO HOSPITAL OR FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7582

CERTIFICATE OF DEATH

07557

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville 8</b>		c. LENGTH OF STAY IN lb <b>42 YRS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>30 Old Court Rd</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LORETTO</b> Middle <b>G.</b> Last <b>CREAGHAN</b>		4. DATE OF DEATH Month <b>July</b> Day <b>27</b> Year <b>1959</b>	
5. SEX <b>Fe</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAR. 7, 1878</b>
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11c. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Flannery</b>		14. MOTHER'S MAIDEN NAME <b>Loretta Mary Noonan</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>SON - Augustine G. Creaghan - Pikesville</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b> <b>12 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic auricular fibrillation</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 5, 1953</b> , to <b>27 July, 1959</b> , that I last saw the deceased alive on <b>27 July, 1959</b> , and that death occurred at <b>2 A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Paul H Royse</b>		ADDRESS (Street, city or town, state) <b>808 Reisterstown Rd</b>	
PHYSICIAN'S NAME (Type) <b>Paul H Royse</b>		DATE SIGNED <b>27 July 59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/29/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Thos. J. Dickener &amp; Sons - Balt.</b>		24a. REC'D BY REGISTRAR <b>DATE 28 59</b>	
24b. REGISTRAR'S SIGNATURE <b>Carlton S. Frank</b>			



07558

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN lb <b>3 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> <b>3 YOI-4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>2011 McCulloch Street</b> <b>(17)</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JAMES</b>		First <b>W.</b> Middle <b>CROXTON</b> Last		4. DATE OF DEATH Month <b>July</b> Day <b>24</b> Year <b>1959</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>June 24, 1888</b>		9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>15</b> Hours <b>59</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Scrap Yard</b>		11. BIRTHPLACE (State or foreign country) <b>Lancaster Co., Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Ned Croxton</b>		14. MOTHER'S MAIDEN NAME <b>Bertha Williams</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes</b> <b>WW I</b>		16. SOCIAL SECURITY NO. <b>217-05-8121</b>		17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RETROPERITONEAL FIBROSARCOMA</b> <b>158X</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>2 YEARS</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>Operation 2/6/59 Transverse Colostomy</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>VA</b>	
20f. (City or town) <b>VA</b>		(County) <b>VA</b>		(State) <b>VA</b>	
21. I certify that I attended the deceased from <b>July 21, 1959</b> , to <b>July 24, 1959</b> , and that death occurred at <b>3:20 A.M.</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b>		DATE SIGNED <b>7/24/59</b>	
ACTUAL SIGNATURE <b>John W. Crawford</b>		PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b>		DATE SIGNED <b>7/24/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-28-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>	
22d. LOCATION (City, town, or county) <b>Baltimore</b>		(State) <b>Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>George G. Nelson</b>		ADDRESS <b>1348 N. Calhoun St.</b>		24a. REC'D BY REGISTRAR <b>JUL 27 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>					

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7584

## CERTIFICATE OF DEATH

07559

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>16 Hrs. 50 M.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>503 Cumberland Street</b>	
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>B.</b> Last <b>CROXTON</b>		4. DATE OF DEATH Month <b>July</b> Day <b>29</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 15, 1894</b>
9. AGE (In years last birthday) <b>65</b>		10. IF UNDER 1 YEAR: Months Days Hours Min. <b>65</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffeur</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Private Family</b>	
11. BIRTHPLACE (State or foreign country) <b>Heathsville, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Charles Croxton</b>		14. MOTHER'S MAIDEN NAME <b>Helen Leland</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO. <b>217-20-0849</b>	
17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE, ACUTE</b> DUE TO ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>3 YEARS</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 WEEK</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6:00 PM 7/28, 19 59</b> to <b>8:50 AM 7/29/59</b> and that death occurred at <b>8:50 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John W. Crawford</b>		M.D. <b>VAH, FORT HOWARD, MARYLAND</b>	
PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b>		DATE SIGNED <b>7/29/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-3-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles R. Law</b>		ADDRESS <b>802 Madison Ave/Balto. Md.</b>	
24a. REC'D BY REGISTRAR <b>JUL 31 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Howard</b>	





7585

CERTIFICATE OF DEATH

07560

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore - 19</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>as</i> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sparrows Pt.</i>		c. LENGTH OF STAY IN 1b <i>36 yrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>W</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>7329 Geis Ave.</i>				d. STREET ADDRESS <i>#1</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>ANTHONY</i> Middle <i>+++</i> Last <i>DAPKUS</i>				4. DATE OF DEATH Month <i>JULY</i> Day <i>12</i> Year <i>1959</i>			
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>July 1, 1874</i>	
				9. AGE (In years last birthday) <i>85</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>Electrical repairman Steel co</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Steel co</i>		11. BIRTHPLACE (State or foreign country) <i>Lithuania</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>unknown</i>				14. MOTHER'S MAIDEN NAME <i>unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>213-07-2975</i>		17. INFORMANT <i>Philomena Long</i> Address <i>address as in #1</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Failure</i> <i>443X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive Cardiovascular disease</i> DUE TO (c) <i>Chorea</i>							INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July 7</i> , 19 <i>59</i> , to <i>July 12</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>July 7</i> , 19 <i>59</i> , and that death occurred at <i>7 A</i> . M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Louis N. Tolkin</i>				ADDRESS (Street, city or town, state) <i>6908 N. Point Rd Baltimore - 19 - Md</i>		DATE SIGNED <i>7/12/59</i>	
PHYSICIAN'S NAME (Type) <i>Louis N. Tolkin</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7/15/59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore Co., Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Walter Brooks Bradley</i>				ADDRESS <i>Dundalk 22, Md</i>		24a. REC'D BY REGISTRAR DATE <i>JUL 14 '59</i>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1922

012500

FILE NO.

<p>1. NAME OF DECEASED                  [Handwritten: Mary Ellen Sullivan]</p>		<p>2. SEX                  [Handwritten: Female]</p>	
<p>3. AGE                  [Handwritten: 42 years]</p>		<p>4. DATE OF BIRTH                  [Handwritten: 1880]</p>	
<p>5. PLACE OF BIRTH                  [Handwritten: Boston, Mass.]</p>		<p>6. OCCUPATION                  [Handwritten: None]</p>	
<p>7. CAUSE OF DEATH                  [Handwritten: Heart Disease]</p>		<p>8. MANNER OF DEATH                  [Handwritten: Natural]</p>	
<p>9. DATE OF DEATH                  [Handwritten: 1922-07-10]</p>		<p>10. TIME OF DEATH                  [Handwritten: 10:30 AM]</p>	
<p>11. PLACE OF DEATH                  [Handwritten: Home]</p>		<p>12. SIGNATURE OF PHYSICIAN                  [Handwritten: J. H. Sullivan]</p>	
<p>13. SIGNATURE OF REGISTRAR                  [Handwritten: J. H. Sullivan]</p>		<p>14. SIGNATURE OF DECEASED                  [None]</p>	

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7586

## CERTIFICATE OF DEATH

07561

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upperco</u>			c. LENGTH OF STAY IN 1b <u>40 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upperco</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EMORY Road</u>				d. STREET ADDRESS <u>EMORY Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William BRADLEY Davidson</u>				4. DATE OF DEATH Month Day Year <u>July 20 1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 8, 1881</u>	
9. AGE (In years, last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>agriculture</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>SAMPSON Davidson</u>				14. MOTHER'S MAIDEN NAME <u>SALLY BROWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>216-14-0164</u>		17. INFORMANT Address <u>Paul Davidson, HAMPSTEAD Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> <u>177X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Primary Carcinoma of Prostate</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Atherosclerotic Cardiovascular Disease</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>August 15, 1958</u> , to <u>July 20, 1959</u> , that I last saw the deceased alive on <u>July 20, 1959</u> , and that death occurred at <u>5:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph E. Bush</u>				ADDRESS (Street, city or town, state) <u>Hampstead, Maryland</u>			
DATE SIGNED <u>May 17 7/20/59</u>							
PHYSICIAN'S NAME (Type) <u>Joseph E. Bush</u>				HAMPSTEAD Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town or county) (State)	
<u>Burial</u>		<u>7-23-1959</u>		<u>Wesley</u>		<u>Wesley Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw Epton-Hampstead Md</u>				ADDRESS <u>Hampstead Md</u>		24a. REG'D BY REGISTRAR DATE <u>JUL 24 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>							



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7587

## CERTIFICATE OF DEATH

Reg. Dist. No.

07562

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville 28</b> c. LENGTH OF STAY IN 1b <b>28</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Paradise Nursing Home</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> <b>1919 Breitwert Ave., Balto. City, Md.</b> b. COUNTY <b>Balto. City, Md.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City</b> d. STREET ADDRESS <b>1919 Breitwert Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Andrew Debus</b> First Middle Last		4. DATE OF DEATH <b>July 22, 1959</b> Month Day Year	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 11, 1874</b>
9. AGE (In years last birthday) <b>85</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shipping Clerk -ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Continental Can</b>	
11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Nephew</b> Address <b>Wilmar Debus, 3329 Clifmont Av. Balto. 23,</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>6 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 16, 1947</b> , to <b>July 22, 1959</b> , that I last saw the deceased alive on <b>July 20, 1959</b> , and that death occurred at <b>9:07 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>C. Arthur Rossberg</b> M.D.		ADDRESS (Street, city or town, State) <b>2436 Washington Blvd Baltimore 30, Md.</b>	
DATE SIGNED <b>7/24/59</b>			
PHYSICIAN'S NAME (Type) <b>C. ARTHUR ROSSBERG MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/25/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Western</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore City, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc., 1217 St. Paul St., Balto. 2, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 27 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			





TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No.

07563

7588

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Mercy Villa Rest Home</i>		d. STREET ADDRESS <i>1513 Tomlaw Rd.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Angela</i> Middle <i>Delclos</i> Last <i>Delclos</i>		4. DATE OF DEATH Month <i>July</i> Day <i>1</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-31-1875</i>
9. AGE (In years last birthday) yrs. <i>83</i>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Spain</i>	
11. BIRTHPLACE (State or foreign country) <i>Spain</i>		12. CITIZEN OF WHAT COUNTRY? <i>Spain</i> ✓	
13. FATHER'S NAME <i>Anthony Reinal</i>		14. MOTHER'S MAIDEN NAME <i>Mary Joerster</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>John Delclos</i>	
17. INFORMANT <i>same</i>		Address <i>same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Cerebral Occlusion</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive Arteriosclerosis</i> DUE TO <i>20 years</i> (c) <i>Cardiovascular Disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 hours</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1954</i> , 19 <i>7/1</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>June</i> , 19 <i>58</i> , and that death occurred at <i>3:30 P.M.</i> from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <i>14 E. Engle St Baltimore 2</i> DATE SIGNED <i>7/1/59</i>			
ACTUAL SIGNATURE <i>Wilfred H. Townshend</i> M.D.			
PHYSICIAN'S NAME (Type) <i>Wilfred H. Townshend, Jr., M. D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7-4-59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		ADDRESS <i>5305 Harford Rd.</i>	
24a. REC'D BY REGISTRAR <i>JUL 6 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Haines</i>	

115252

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>	
<p>7. MARITAL STATUS</p>		<p>8. CAUSE OF DEATH</p>	
<p>9. MEDICAL HISTORY</p>		<p>10. SIGNATURE OF REGISTRAR</p>	
<p>11. SIGNATURE OF WITNESSES</p>		<p>12. DATE OF DEATH</p>	
<p>13. PLACE OF DEATH</p>		<p>14. SIGNATURE OF DECEASED</p>	
<p>15. SIGNATURE OF NEAREST RELATIVE</p>		<p>16. SIGNATURE OF MEDICAL OFFICER</p>	
<p>17. SIGNATURE OF PRIEST</p>		<p>18. SIGNATURE OF CHURCH OFFICER</p>	
<p>19. SIGNATURE OF BURIAL OFFICER</p>		<p>20. SIGNATURE OF INTERMENT OFFICER</p>	
<p>21. SIGNATURE OF FUNERAL HOME</p>		<p>22. SIGNATURE OF CEMETERY</p>	
<p>23. SIGNATURE OF BURIAL SOCIETY</p>		<p>24. SIGNATURE OF BURIAL SOCIETY</p>	
<p>25. SIGNATURE OF BURIAL SOCIETY</p>		<p>26. SIGNATURE OF BURIAL SOCIETY</p>	
<p>27. SIGNATURE OF BURIAL SOCIETY</p>		<p>28. SIGNATURE OF BURIAL SOCIETY</p>	
<p>29. SIGNATURE OF BURIAL SOCIETY</p>		<p>30. SIGNATURE OF BURIAL SOCIETY</p>	
<p>31. SIGNATURE OF BURIAL SOCIETY</p>		<p>32. SIGNATURE OF BURIAL SOCIETY</p>	
<p>33. SIGNATURE OF BURIAL SOCIETY</p>		<p>34. SIGNATURE OF BURIAL SOCIETY</p>	
<p>35. SIGNATURE OF BURIAL SOCIETY</p>		<p>36. SIGNATURE OF BURIAL SOCIETY</p>	
<p>37. SIGNATURE OF BURIAL SOCIETY</p>		<p>38. SIGNATURE OF BURIAL SOCIETY</p>	
<p>39. SIGNATURE OF BURIAL SOCIETY</p>		<p>40. SIGNATURE OF BURIAL SOCIETY</p>	
<p>41. SIGNATURE OF BURIAL SOCIETY</p>		<p>42. SIGNATURE OF BURIAL SOCIETY</p>	
<p>43. SIGNATURE OF BURIAL SOCIETY</p>		<p>44. SIGNATURE OF BURIAL SOCIETY</p>	
<p>45. SIGNATURE OF BURIAL SOCIETY</p>		<p>46. SIGNATURE OF BURIAL SOCIETY</p>	
<p>47. SIGNATURE OF BURIAL SOCIETY</p>		<p>48. SIGNATURE OF BURIAL SOCIETY</p>	
<p>49. SIGNATURE OF BURIAL SOCIETY</p>		<p>50. SIGNATURE OF BURIAL SOCIETY</p>	
<p>51. SIGNATURE OF BURIAL SOCIETY</p>		<p>52. SIGNATURE OF BURIAL SOCIETY</p>	
<p>53. SIGNATURE OF BURIAL SOCIETY</p>		<p>54. SIGNATURE OF BURIAL SOCIETY</p>	
<p>55. SIGNATURE OF BURIAL SOCIETY</p>		<p>56. SIGNATURE OF BURIAL SOCIETY</p>	
<p>57. SIGNATURE OF BURIAL SOCIETY</p>		<p>58. SIGNATURE OF BURIAL SOCIETY</p>	
<p>59. SIGNATURE OF BURIAL SOCIETY</p>		<p>60. SIGNATURE OF BURIAL SOCIETY</p>	
<p>61. SIGNATURE OF BURIAL SOCIETY</p>		<p>62. SIGNATURE OF BURIAL SOCIETY</p>	
<p>63. SIGNATURE OF BURIAL SOCIETY</p>		<p>64. SIGNATURE OF BURIAL SOCIETY</p>	
<p>65. SIGNATURE OF BURIAL SOCIETY</p>		<p>66. SIGNATURE OF BURIAL SOCIETY</p>	
<p>67. SIGNATURE OF BURIAL SOCIETY</p>		<p>68. SIGNATURE OF BURIAL SOCIETY</p>	
<p>69. SIGNATURE OF BURIAL SOCIETY</p>		<p>70. SIGNATURE OF BURIAL SOCIETY</p>	
<p>71. SIGNATURE OF BURIAL SOCIETY</p>		<p>72. SIGNATURE OF BURIAL SOCIETY</p>	
<p>73. SIGNATURE OF BURIAL SOCIETY</p>		<p>74. SIGNATURE OF BURIAL SOCIETY</p>	
<p>75. SIGNATURE OF BURIAL SOCIETY</p>		<p>76. SIGNATURE OF BURIAL SOCIETY</p>	
<p>77. SIGNATURE OF BURIAL SOCIETY</p>		<p>78. SIGNATURE OF BURIAL SOCIETY</p>	
<p>79. SIGNATURE OF BURIAL SOCIETY</p>		<p>80. SIGNATURE OF BURIAL SOCIETY</p>	
<p>81. SIGNATURE OF BURIAL SOCIETY</p>		<p>82. SIGNATURE OF BURIAL SOCIETY</p>	
<p>83. SIGNATURE OF BURIAL SOCIETY</p>		<p>84. SIGNATURE OF BURIAL SOCIETY</p>	
<p>85. SIGNATURE OF BURIAL SOCIETY</p>		<p>86. SIGNATURE OF BURIAL SOCIETY</p>	
<p>87. SIGNATURE OF BURIAL SOCIETY</p>		<p>88. SIGNATURE OF BURIAL SOCIETY</p>	
<p>89. SIGNATURE OF BURIAL SOCIETY</p>		<p>90. SIGNATURE OF BURIAL SOCIETY</p>	
<p>91. SIGNATURE OF BURIAL SOCIETY</p>		<p>92. SIGNATURE OF BURIAL SOCIETY</p>	
<p>93. SIGNATURE OF BURIAL SOCIETY</p>		<p>94. SIGNATURE OF BURIAL SOCIETY</p>	
<p>95. SIGNATURE OF BURIAL SOCIETY</p>		<p>96. SIGNATURE OF BURIAL SOCIETY</p>	
<p>97. SIGNATURE OF BURIAL SOCIETY</p>		<p>98. SIGNATURE OF BURIAL SOCIETY</p>	
<p>99. SIGNATURE OF BURIAL SOCIETY</p>		<p>100. SIGNATURE OF BURIAL SOCIETY</p>	

115252

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7589

## CERTIFICATE OF DEATH

07564

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> 19 MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>AS</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SPARROWS Pt</b>				c. LENGTH OF STAY IN 1b <b>8 mo.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>IN</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WHITE AVE</b>				d. STREET ADDRESS <b>#1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JULIA</b> Middle <del>XXXXXXXX</del> Last <b>DEMSKI</b>				4. DATE OF DEATH Month <b>JULY</b> Day <b>2</b> Year <b>1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>NOV. 12. 1885</b>	
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months Days Hours		IF UNDER 24 HRS. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WALTER OLZHEWSKI</b>				14. MOTHER'S MAIDEN NAME <b>ANNA. LAMPKE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>None</b>		17. INFORMANT Address <b>John. Demski (Husband)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Acute Coronary failure with pulmonary edema.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis. Hypertensive</b> DUE TO <b>Cardiovascular disease.</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b> <b>6 years</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov 28</b> , 19 <b>58</b> , to <b>July 2</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>July 2</b> , 19 <b>59</b> , and that death occurred at <b>3 P.</b> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Louis N. Tollin</b> M.D.				ADDRESS (Street, city or town, state) <b>6908 N. Pt. Rd.</b>		DATE SIGNED <b>July 2/59</b>	
PHYSICIAN'S NAME (Type) <b>Louis N. Tollin M.D.</b>				<b>Balto. 19. Md</b>			
22a. BURIAL, CREMATION, or other disposal (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-6-1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart of Mary</b>		22d. LOCATION (City, town, or county) (State) <b>Gorman Hill Rd. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Duda</b>				ADDRESS <b>7922 Wise Ave. 22, Md.</b>		24a. REC'D BY REGISTRAR <b>59</b> DATE <b>JUL 6</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Howard</b>			



TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

7590

# CERTIFICATE OF DEATH

Reg. Dist. No. 07565

1. PLACE OF DEATH o. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Carney</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Carney</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>9205 Harford Rd.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Catherine</i> Middle <i>E.</i> Last <i>Denn</i>		4. DATE OF DEATH Month <i>July</i> Day <i>6</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-17-1869</i>
9. AGE (In years last birthday) <i>89</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>William H. Chipley</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Smith</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>INFORMANT</i> Address <i>Charles Denn 1360 Winston Ave. Balto.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Coronary Thrombosis</i> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) <i>Atherosclerosis</i> (c) <i>Age</i>		INTERVAL BETWEEN ONSET AND DEATH <i>24 H.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>7/4</i> , 19 <i>59</i> , to <i>7/5</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>July 5</i> , 19 <i>59</i> , and that death occurred at <i>3:00</i> A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Frank T. Kasik</i>		DATE SIGNED <i>9/6/59</i>	
PHYSICIAN'S NAME (Type) <i>FRANK T. KASIK</i>		ADDRESS (Street, city or town, state) <i>9005 HARFORD RD. BALTO 14 Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7-8-59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Chestnut Grove Cem.</i>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		23b. REGISTRAR'S SIGNATURE <i>Arthur E. Kraus</i>	
ADDRESS <i>5305 Harford Rd.</i>		24a. REC'D BY REGISTRAR DATE <i>JUL 7 '59</i>	

07552

CENTRAL OFFICE

1930

*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some words like "CENTRAL OFFICE" and "1930" are visible.]*



FOR STATE  
HEALTH DEPT.

7591

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07566

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Colgate (24)</b>				c. LENGTH OF STAY IN Tb <b>Colgate (24)</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>401 Oriole Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Willie</b> Middle <b>Maye</b> Last <b>Dickerson</b>				4. DATE OF DEATH Month <b>July</b> Day <b>21</b> Year <b>19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 12, 1905</b>	9. AGE (In years last birthday) <b>53 yrs.</b>	IF UNDER 1 YEAR Months <b>53</b> Days <b>21</b> Hours <b>59</b> Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Mississippi</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>UNKNOWN</b>				14. MOTHER'S MAIDEN NAME <b>Molly Doury</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-16-5503</b>		17. INFORMANT <b>Mauric Dickerson</b>		Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CIRRHOSIS OF LIVER (Alcoholic)</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>					
20c. TIME OF INJURY Hour <b>19</b> a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>M B Davis</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>M.B. DAVIS M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>7/22/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Brookhaven Funeral Home</b>		22d. LOCATION (City, town, or county) (State) <b>Lincoln Co., Miss.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James E. Bruzdziński</b>				24a. REC'D BY REGISTRAR <b>JUL 23 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

MEDICAL CERTIFICATION

00288

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12584

FOR STATE  
HEALTH DEPT



1. Name of Deceased: John Doe

2. Sex: Male

3. Age: 45

4. Date of Birth: 10/15/1920

5. Place of Birth: New York City, N.Y.

6. Usual Residence: 123 Main St., Baltimore, Md.

7. Date of Death: 11/10/1965

8. Time of Death: 10:30 AM

9. Place of Death: Home

10. Cause of Death: Myocardial Infarction

11. Manner of Death: Natural

12. Signature of Medical Examiner: [Signature]

13. Title: Medical Examiner

14. Date: 11/10/65

15. Office: Baltimore, Md.

TO HOSPITAL OR TO FUNERAL HOME: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)  
ISM 9/58

7592 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

Reg. Dist. No. 07567

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7143 Holabird Ave</u>		d. STREET ADDRESS <u>7143 Holabird Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Orsola</u> Middle <u>L</u> Last <u>Dixon</u>		4. DATE OF DEATH Month <u>July</u> Day <u>5</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>June 5 1899</u>
9. AGE (In years last birthday) <u>59</u>		10. F UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>me</u>	
11. BIRTHPLACE (State or foreign country) <u>Me</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Benjamin F Friend</u>		14. MOTHER'S MAIDEN NAME <u>Sarah J Friend</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Mrs. Maud Eike 7143 Holabird</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension cardio-vascular disease</u> DUE TO (c) <u>Diabetes mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 mos</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 15</u> , 1957, to <u>7-5</u> , 1959, that I last saw the deceased alive on <u>7-5</u> , 1959, and that death occurred at <u>7:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Eugene F. Newy</u>		ADDRESS (Street, city or town, state) <u>7001 Mornington Rd</u>	
PHYSICIAN'S NAME (Type) <u>Eugene F Newy</u>		DATE SIGNED <u>Dundalk 22, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removed July 6/59</u>		22b. DATE THEREOF <u>July 6/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Blooming Rose Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Oakland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William J. Hines</u>		ADDRESS <u>2112 Dundalk</u>	
24a. REC'D BY REGISTRAR <u>JUL 7 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hunt</u>	



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7593

## CERTIFICATE OF DEATH

Reg. Dist. No. 07568

1. PLACE OF DEATH a. COUNTY <b>BALTO.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTO.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ESSEX (21)</b>		c. LENGTH OF STAY IN lb <b>LIFE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>361 STILLWATER RD.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>JULIA</b> Last <b>DORN</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>8</b> Year <b>1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV. 11, 1895</b>
9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE, AT HOME</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BALTO. MD.</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>NOT KNOWN</b>		14. MOTHER'S MAIDEN NAME <b>NOT KNOWN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>EUGENE DORN</b>		Address <b>361 STILLWATER RD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> 260x DUE TO <b>Arteriosclerotic Cardio Vascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Diabetes Mellitus</b> (c) <b>Diabetes Mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1</b> , 19 <b>57</b> , to <b>July 8</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>July 8</b> , 19 <b>59</b> , and that death occurred at <b>1:00 A.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Balls Blv md</b> DATE SIGNED <b>7/14/59</b>	
ACTUAL SIGNATURE <b>G. BAKMGARDNER</b> M.D.		PHYSICIAN'S NAME (Type) <b>G. BAKMGARDNER 8557 PHILADELPHIA RD.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>JULY 11, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>PARK WOOD</b>		22d. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>George W. Hoffmann</b>		ADDRESS <b>3218 Hudson St</b>	
24a. REC'D BY REGISTRAR <b>JUL 14 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

67208

## CERTIFICATE OF DEATH

1953

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

Reg. No. 100

DATE OF DEATH  
JULY 15 1953  
PLACE OF DEATH  
HOME

DECEASED

AUTO

EDUCATION

HIGH SCHOOL

OCCUPATION

NONE

MARRIAGE

NONE

SINGLE

NONE

MARRIED

NONE

DIVORCED

NONE

WIDOWED

NONE

MARRIED

NONE

MARRIED

NONE

MARRIED

NONE

MARRIED

NONE

MARRIED

NONE

MARRIED

NONE

MARRIED

NONE

MARRIED

NONE

MARRIED

NONE

MARRIED

NONE

MARRIED

NONE

MARRIED

NONE

MARRIED

NONE

MARRIED

NONE

MARRIED

NONE

MARRIED

NONE

MARRIED

NONE

MARRIED

NONE

MARRIED

NONE

MARRIED

NONE

MARRIED

NONE

MARRIED

NONE

MARRIED

NONE

MARRIED

NONE

MARRIED

NONE

MARRIED

NONE

MARRIED

NONE

MARRIED

NONE

MARRIED

NONE

MARRIED

NONE

MARRIED

NONE

MARRIED

NONE

MARRIED

NONE

MARRIED

NONE

MARRIED

NONE

MARRIED

NONE

MARRIED

NONE

MARRIED

NONE

MARRIED

NONE

MARRIED

NONE

MARRIED

NONE

MARRIED

NONE

MARRIED

NONE

MARRIED

NONE

MARRIED

NONE

MARRIED

NONE

MARRIED

NONE

MARRIED

NONE



TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7594

## CERTIFICATE OF DEATH

07569

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore County</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>5 Mos. 22 Das.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> <b>47X-3</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Sheppard and Enoch Pratt Hospital</b>				d. STREET ADDRESS <b>1520 H Street, N. W.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Noah</b> Middle <b>Ernest</b> Last <b>Dorsey</b>				4. DATE OF DEATH Month <b>July</b> Day <b>6</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 15, 1873</b>	
9. AGE (In years last birthday) <b>86</b> yrs.		IF UNDER 1 YEAR Months <b>86</b> Days <b>86</b> Hours <b>86</b> Min.		IF UNDER 24 HRS. Months <b>86</b> Days <b>86</b> Hours <b>86</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Physicist</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Lloyd E. Dorsey</b>				14. MOTHER'S MAIDEN NAME <b>Laura Worthington</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>_____</b>		17. INFORMANT <b>Hospital Records</b> Address <b>_____</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho pneumonia</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic myocarditis</b> DUE TO (c) <b>Generalized arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>4 da</b> <b>1 yr +</b> <b>11 h</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>Chronic Brain Syndrome</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>19</b> o. m. <b>_____</b> p. m. <b>_____</b> Month <b>_____</b> Day <b>_____</b> Year <b>1959</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Jan 14, 1959</b> to <b>July 6, 1959</b> , that I last saw the deceased alive on <b>July 4, 1959</b> , and that death occurred at <b>4:26 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>W.W. Elgin</b>				ADDRESS (Street, city or town, state) <b>The Sheppard and Enoch Pratt Hospital, Towson 4, Maryland</b> DATE SIGNED <b>7/6/59</b>			
PHYSICIAN'S NAME (Type) <b>W. W. Elgin, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>July 8, 1959</b>		<b>Lansing Family Cem</b>		<b>Annapolis Junction</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Elgin</b>				ADDRESS <b>Laurel, Md.</b>		24a. REC'D BY REGISTRAR <b>SOB 10-59</b> DATE <b>7/6/59</b>	
24b. REGISTRAR'S SIGNATURE <b>W. W. Elgin</b>							

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

10-00

10-00

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. DATE OF DEATH</p>	
<p>7. TIME OF DEATH</p>		<p>8. PLACE OF DEATH</p>	
<p>9. CAUSE OF DEATH</p>		<p>10. MANNER OF DEATH</p>	
<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF REGISTRAR</p>	
<p>13. SIGNATURE OF WITNESS</p>		<p>14. SIGNATURE OF DECEASED</p>	
<p>15. SIGNATURE OF NEXT OF KIN</p>		<p>16. SIGNATURE OF BURIAL OFFICIAL</p>	
<p>17. SIGNATURE OF CHURCH OFFICIAL</p>		<p>18. SIGNATURE OF FUNERAL HOME</p>	
<p>19. SIGNATURE OF CEMETERY OFFICIAL</p>		<p>20. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>21. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>22. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>23. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>24. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>25. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>26. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>27. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>28. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>29. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>30. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>31. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>32. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>33. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>34. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>35. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>36. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>37. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>38. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>39. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>40. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>41. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>42. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>43. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>44. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>45. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>46. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>47. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>48. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>49. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>50. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>51. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>52. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>53. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>54. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>55. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>56. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>57. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>58. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>59. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>60. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>61. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>62. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>63. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>64. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>65. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>66. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>67. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>68. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>69. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>70. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>71. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>72. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>73. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>74. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>75. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>76. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>77. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>78. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>79. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>80. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>81. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>82. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>83. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>84. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>85. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>86. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>87. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>88. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>89. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>90. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>91. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>92. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>93. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>94. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>95. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>96. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>97. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>98. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>99. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>100. SIGNATURE OF INTERMENT OFFICIAL</p>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
7595											
CERTIFICATE OF DEATH											
Reg. Dist. No. 07570											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Reisterstown</b>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>19 Bond Ave.</b>					d. STREET ADDRESS <b>19 Bond Ave.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ERNEST</b> Middle <b>DUTTON</b> Last <b>DUTTON</b>					4. DATE OF DEATH Month <b>July</b> Day <b>24</b> Year <b>59</b>						
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 19, 1919</b>		9. AGE (In years last birthday) yrs. <b>39</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>					10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			
13. FATHER'S NAME <b>Alfred Dutton</b>					14. MOTHER'S MAIDEN NAME <b>Fannie Little</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT Address <b>M's Margaret Dutton 19 Bond Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Decompensation</b> <b>434.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>none</b> DUE TO (c) <b>none</b>								INTERVAL BETWEEN ONSET AND DEATH <b>3 mos.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Nephritis</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>none</b>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>none</b> p. m. <b>none</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>none</b>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State) <b>none</b>			
21. I certify that I attended the deceased from <b>3-21-58</b> , 19____, to <b>7-24-59</b> , 19____, that I last saw the deceased alive on <b>7-23-59</b> , 19____, and that death occurred at <b>1 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6 Hanover Rd.</b> DATE SIGNED <b>7-25-59</b> ACTUAL SIGNATURE <b>D. D. Caples</b> M.D. <b>Reisterstown, Md.</b> PHYSICIAN'S NAME (Type) <b>D. D. Caples, M. D.</b>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			22b. DATE THEREOF <b>7-28-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Lukes Cem.</b>			22d. LOCATION (City, town, or county) (State) <b>Reisterstown, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Mr<sup>s</sup> Frances A. Hemsley</b>					ADDRESS <b>578 W. Biddle St</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 29 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hems</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7596

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

07571

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince George's</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville 28.</u>		c. LENGTH OF STAY IN 1b <u>6 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BLADENSBURG 16 33.2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove St. Hosp.</u>			d. STREET ADDRESS <u>4302 51st street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Lottie</u> Middle <u>DUVALL</u> Last <u>DUVALL</u>			4. DATE OF DEATH Month <u>7</u> Day <u>5</u> Year <u>1959</u>		
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-29-78</u>		9. AGE (In years last birthday) <u>81</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			13. FATHER'S NAME <u>Charles Crab</u>		
14. MOTHER'S MAIDEN NAME <u>Virginia Latchford</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <u>—</u>			17. INFORMANT <u>Hospital records</u>		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolus.</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic C.V.D.</u> DUE TO (c) <u>unknown</u>				INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>June 29, 1959</u> , to <u>July 5<sup>th</sup>, 1959</u> , that I last saw the deceased alive on <u>July 5<sup>th</sup>, 1959</u> , and that death occurred at <u>1:45 PM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Gertrude J. Fleischmann, M.D.</u>				ADDRESS (Street, city or town, state) <u>Spring Grove St. Hosp.</u> DATE SIGNED <u>7.5.1959</u>	
PHYSICIAN'S NAME (Type) <u>GERTRUDE J. FLEISCHMANN M.D.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/7/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Mem Park, Carey, Md</u>	
22d. LOCATION (City, town, or county)		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>De Witt Donaldson, Laurel Md</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 7 59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hays</u>	





TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7597 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

Reg. Dist. No. 07572

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>23 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>B.</b> Last <b>DYSON</b>				4. DATE OF DEATH Month <b>July</b> Day <b>8</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 2, 1893</b>	
9. AGE (In years last birthday) <b>66</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Odd jobs</b>		11. BIRTHPLACE (State or foreign country) <b>St. Mary's Co., Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				13. FATHER'S NAME <b>John J. Dyson</b>			
14. MOTHER'S MAIDEN NAME <b>Emma Jones</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW I</b>			
16. SOCIAL SECURITY NO. <b>217-01-4585</b>				17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOGENIC CARCINOMA, RIGHT UPPER LOBE</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>THORACOTOMY, RIGHT July 7, 1959</b>				INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>June 15</b> , 19 <b>59</b> , to <b>July 8</b> , 19 <b>59</b> , and that death occurred at <b>12:02A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Donald D. Mark</i>				ADDRESS (Street, city or town, state) <b>M.D. YAH, FORT HOWARD, MARYLAND</b>			
DATE SIGNED <b>7/8/59</b>				PHYSICIAN'S NAME (Type) <b>DONALD D. MARK, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>7/11/1959</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>St. Peters Cemetery</b>				22d. LOCATION (City, town, or county) (State) <b>Bentlow, Laurens, Balto. Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Katie Williams</i> <b>Katie Williams Funeral Home, 322 N. Schroeder St., Baltimore, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 13 '59</b>			
24b. REGISTRAR'S SIGNATURE <i>Carlton E. Evans</i>							



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7598

## CERTIFICATE OF DEATH

07573

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>New Jersey</b> b. COUNTY <b>Camden</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>322 Dixie Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ELLA</b> First <b>May</b> Middle <b>EDWARDS</b> Last		4. DATE OF DEATH Month <b>JULY</b> Day <b>18</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 22, 1876</b>
9. AGE (In years last birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13. FATHER'S NAME <b>Franklin Jones</b>		14. MOTHER'S MAIDEN NAME <b>Amanda Turner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Raymond Miller, Jr.</b>		Address <b>322 Dixie Drive</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> 181.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>AZOTEMIA</b> DUE TO (c) <b>CARCINOMA OF BLADDER</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b> <b>3 MONTHS</b> <b>6 MONTHS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7/15</b> , 19 <b>59</b> , to <b>7/18</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>7/18</b> , 19 <b>59</b> , and that death occurred at <b>8:10 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Donald L. Somerville</b>		ADDRESS (Street, city or town, state) <b>25 W. Pennsylvania Avenue</b>	
PHYSICIAN'S NAME (Type) <b>DONALD L. SOMERVILLE, M.D.</b>		DATE SIGNED <b>7/18/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 22, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Harleigh</b>		22d. LOCATION (City, town, or county) (State) <b>Camden, New Jersey</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John O. Mitchell &amp; Sons, Inc.</b>		24a. REC'D BY REGISTRAR <b>JUL 23 '59</b>	
ADDRESS <b>1900 Eutaw Place</b>		24b. REGISTRAR'S SIGNATURE <b>Charles P. Hume</b>	
<b>Baltimore, 17, Maryland</b>			

10-1-53

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

10-1-53

DECEASED'S NAME [Illegible]		SEX [Illegible]		AGE [Illegible]	
DATE OF DEATH [Illegible]		PLACE OF DEATH [Illegible]		COUNTY [Illegible]	
TIME OF DEATH [Illegible]		CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]	
PLACE OF BIRTH [Illegible]		DATE OF BIRTH [Illegible]		SEX [Illegible]	
OCCUPATION [Illegible]		EDUCATION [Illegible]		RELIGION [Illegible]	
MARITAL STATUS [Illegible]		PREVIOUS MARRIAGES [Illegible]		PRESENT ADDRESS [Illegible]	
DATE OF MARRIAGE [Illegible]		PLACE OF MARRIAGE [Illegible]		NAME OF SPouse [Illegible]	
DATE OF DEATH [Illegible]		PLACE OF DEATH [Illegible]		COUNTY [Illegible]	
TIME OF DEATH [Illegible]		CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]	
PLACE OF BIRTH [Illegible]		DATE OF BIRTH [Illegible]		SEX [Illegible]	
OCCUPATION [Illegible]		EDUCATION [Illegible]		RELIGION [Illegible]	
MARITAL STATUS [Illegible]		PREVIOUS MARRIAGES [Illegible]		PRESENT ADDRESS [Illegible]	
DATE OF MARRIAGE [Illegible]		PLACE OF MARRIAGE [Illegible]		NAME OF SPouse [Illegible]	

This certificate is to be filled out by the physician or other qualified person who attended the deceased at the time of death. It should be filled out as soon as possible after death and before the body is buried or cremated. It is a legal document and its contents are subject to the laws of the State of Maryland.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7546

Item 1 FilmG244 7-23-59 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

07574

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c. LENGTH OF STAY IN 1b <b>53</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Private home.</b> <b>5 Winona Ave.</b>			d. STREET ADDRESS <b>300 Wise Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Sue</b> Middle <b>Virginia</b> Last <b>Eilerman</b>			4. DATE OF DEATH Month <b>July</b> Day <b>11</b> Year <b>59</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 26, 1885</b>		9. AGE (In years and birthday) yrs. <b>74</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Oxford, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Benjamin Walmsley</b>			14. MOTHER'S MAIDEN NAME <b>Martha Washington</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Mr. Fred Eilerman Sr.</b> Address <b>300 Wise Ave. Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>Congestive heart failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>5 years</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <b>1955</b> to <b>11 July, 1959</b> , that I last saw the deceased alive on <b>8 July, 1959</b> , and that death occurred at <b>11 A. M.</b> from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>B. W. Sokolod</b>		M.D. <b>2900 Dunbar Rd.</b>		DATE SIGNED <b>7-13-59</b>	
PHYSICIAN'S NAME (Type) <b>B. W. Sokolod, M.D.</b>		<b>Dundalk-222d</b>			
22a. BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-14-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>	
22d. LOCATION (City, town, or county) <b>Gov. Ritchie Hwy. Md.</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Duda</b>			ADDRESS <b>7922 Wise Ave. 22, Md.</b>		
24a. REC'D BY REGISTRAR <b>DUL 15 '59</b>			24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>		

CERTIFICATE OF DEATH

1940

AT TESTAMENTARY

DECEASED

NAME

AGE

SEX

RACE

DATE

Name of deceased		Age		Sex		Race		Date	
John E. Jones		45		Male		White		1940	
Place of birth		Date of birth		Place of death		Date of death		Cause of death	
Baltimore, Md.		1900		Baltimore, Md.		1940		Heart disease	
Occupation		Marital status		Education		Religion		Previous illness	
Teacher		Married		High School		Catholic		None	
Signature of physician		Signature of registrar		Signature of informant		Signature of witness		Signature of witness	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7599 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07575  
Item 7 Film 6246 8-3-59 et Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>502 Owings Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Elizabeth</b> First <b>Ellis</b> Middle <b>—</b> Last <b>Ellis</b>		4. DATE OF DEATH Month <b>July</b> Day <b>27</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 1, 1876</b>
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months <b>—</b> Days <b>—</b>	IF UNDER 24 HRS. Hours <b>—</b> Min. <b>—</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (State or foreign country) <b>Va.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>George W. Payne</b>	
14. MOTHER'S MAIDEN NAME <b>Sally</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>Mr Robert Ellis - Randallstown</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>—</b> DUE TO (c) <b>—</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fractured left hip</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none Fell in hallway and fractured left hip.</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>12-18-58</b> p. m. <b>—</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>home</b>	20f. (City or town) (County) (State) <b>Reisterstown, Balto., Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>D. D. Caples</b>		DATE SIGNED <b>7-28-59</b>	
EXAMINER'S NAME (Type) <b>D. D. Caples, M. D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7-30-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Oakland</b>	22d. LOCATION (City, town, or county) (State) <b>Carroll Co., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur H. Haight</b>		24a. REC'D BY REGISTRAR <b>Arthur H. Haight</b>	
ADDRESS <b>Stylersville, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur H. Haight</b>	

MEDICAL CERTIFICATION

2

93575

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

MADE IN  
U.S.A.

19

19

19

19

19

TO BE FILLED BY THE MEDICAL EXAMINER  
This certificate is to be filled out by the medical examiner who has examined the body of the deceased and who has determined the cause of death. It is to be filled out in duplicate, one copy to be retained by the medical examiner and the other copy to be forwarded to the State Department of Health.

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

7600

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

07576

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Granite</b>		c. LENGTH OF STAY IN 1b <b>32 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Davis Avenue</b>		e. STREET ADDRESS <b>Davis Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>ELLWOOD</b> Last		4. DATE OF DEATH Month <b>July</b> Day <b>2nd.</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 6, 1869</b>
9. AGE (In years last birthday) <b>89</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Reely</b>		14. MOTHER'S MAIDEN NAME <b>Nancy Jones</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT Address <b>Mrs. Anna Birmingham Davis Ave. Granite, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Labr. Heart Disease</b> <b>421.4</b> DUE TO <b>and heat prostration</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 1, 1959</b> to <b>July 2, 1959</b> , that I last saw the deceased alive on <b>July 2, 1959</b> , and that death occurred at <b>1 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Wm. E. Martin</b>		DATE SIGNED <b>7/3/59</b>	
PHYSICIAN'S NAME (Type) <b>W. E. MARTIN</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/6/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Marys Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Laurel, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Easton Sons</b>		24a. REC'D BY REGISTRAR ADDRESS <b>Catonsville, Md.</b> DATE <b>JUL 7 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>William L. Kraus</b>	

07520

7880

CERTIFICATE OF DEATH

(1)

State of New York  
County of ...  
I, the undersigned, a duly qualified and licensed physician, do hereby certify that on the ... day of ... 19... at ...  
the following named person died:  
Name of deceased ...  
Age ...  
Sex ...  
Race ...  
Cause of death ...  
Disease ...  
Signature of physician ...  
Signature of registrar ...  
Date of death ...

Witness my hand and seal of office this ... day of ... 19...  
Attest:  
Registrar of Vital Statistics  
Signature of Registrar ...  
Date of registration ...

7601

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07577

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b>				c. LENGTH OF STAY IN 1b <b>20 yrs.</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Pikesville</b>				d. STREET ADDRESS <b>15 Maryland Ave.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>15 Maryland Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>NORMAN</b>		First <b>CAROL</b>		Middle <b>EPPLEY</b>		Last	
4. DATE OF DEATH <b>July 9.</b>		Month		Day		Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 28, 1900</b>		9. AGE (in years last birthday) <b>58</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman, Stebbens</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Anderson Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William H. Eppley</b>				14. MOTHER'S MAIDEN NAME <b>Mamie L. Reisinger</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. (If yes, give no. or dates of service) <b>218-09-2613</b>		17. INFORMANT Address <b>Edith R. Eppley- 15 Maryland Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>10 min.</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>					
20c. TIME OF INJURY Hour o. m. p. m. <b>none</b>	Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>	20f. (City or town) <b>none</b>	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>D. D. Caples</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>7-11-59</b>			
EXAMINER'S NAME (Type) <b>D. D. Caples, M. D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7-11-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>DRUID RIDGE</b>		22d. LOCATION (City, town, or county) (State) <b>Pikesville, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Frank H. Newell, Pikesville, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 14 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		

TO DEPUTY REGISTRAR: This certificate should be executed within 24 hours after death. If any delay is necessary, please see page 4 should be executed. Give the certificate to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





**MEDICAL CERTIFICATION**

VS A1S (4)  
ISM 10/57



7603 8092 ~~7004~~ CERTIFICATE OF DEATH

Reg. Dist. No.

02579

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>51 Baltimore 27.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ridgeway Manor Nursing Home</u>				d. STREET ADDRESS <u>4758 Aldgate Green</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANDREW G. FRANK</u>				4. DATE OF DEATH Month Day Year <u>July 2, 1959</u> <u>19</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 8, 1885</u>		9. AGE (In years lost birthday) <u>74</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Adam Hat Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Frank</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Henry J. Frank, son, above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Ascending Colon</u> <u>153.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-16</u> , 19 <u>55</u> , to <u>7-2</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>7-2</u> , 19 <u>59</u> , and that death occurred at <u>9:15 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John P. Unlock, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>1227 Wash. Blvd Baltimore Md</u>			
PHYSICIAN'S NAME (Type) <u>John P. Unlock, Jr.</u>				DATE SIGNED <u>7/3/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/6/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Schimunek</u>				ADDRESS <u>3331 Brehms Lane</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 7 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Travis</u>			

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY CHIEF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

7604  
MAYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07580

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>		c. LENGTH OF STAY IN TB <u>54</u> <u>ESSEX</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>414 LORRAINE AVE.</u>		d. STREET ADDRESS <u>414 LORRAINE AVE.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ERNEST</u> Middle <u>FRANKLIN</u> Last <u>FRANKLIN</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>11</u> Year <u>19 59</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-9-89</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u>70</u> Days <u>70</u> Hours <u>70</u> Min. <u>70</u>	IF UNDER 24 HRS. Hours <u>70</u> Min. <u>70</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GLEN L MARTIN (RETIRED)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>England</u>	
11. BIRTHPLACE (State or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>WILLIAM FRANKLIN</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>218-09-4810</u>	
17. INFORMANT <u>CARRIE FRANKLIN</u>		Address <u>414 LORRAINE AVE. BALTO. 21</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>A-S-E-V- DISEASE</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Hour o. m. p. m. _____ Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>M. B. Davis</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M. B. Davis MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <u>7/13/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-14-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Connolly</u>		ADDRESS <u>418 Eastern Blvd. 211</u>	
24a. REC'D BY REGISTRAR DATE <u>JUL 16 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

07581

7605

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	c. LENGTH OF STAY IN 1b <u>1 month</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Maryland 1556-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		d. STREET ADDRESS <u>8116 Tohoma Drive</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Frymire</u> Last <u>Frymire</u>		4. DATE OF DEATH Month <u>July</u> Day <u>2</u> Year <u>19 59</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 30, 1885</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>post office worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Post Office</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Elwood Frymire</u>		14. MOTHER'S MAIDEN NAME <u>Theresa Tufel</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> <u>443x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiac fibrillation</u> DUE TO (c) <u>Hypertensive cardiovascular disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 month</u> <u>years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 2</u> , 19 <u>59</u> , to <u>July 2</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 2</u> , 19 <u>59</u> , and that death occurred at <u>9:30a</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stella Wachslar</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>SPRING GROVE STATE HOSPITAL 7-2-59</u>	
PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>		<u>Catonsville 28, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>7/5/59</u>	<u>Harmony</u>	<u>Milton, Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Matteson</u>		ADDRESS <u>28</u>	
24a. REC'D BY REGISTRAR DATE <u>JUL 6 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles L. King</u>	

CERTIFICATE OF DEATH

Page No. 1

<p>1. Name of Deceased: <u>JOHN J. BROWN</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of Birth: <u>1915</u></p>		<p>4. Date of Death: <u>1975</u></p>	
<p>5. Place of Birth: <u>MASSACHUSETTS</u></p>		<p>6. Place of Death: <u>MASSACHUSETTS</u></p>	
<p>7. Usual Residence: <u>123 Main St, Boston, MA</u></p>		<p>8. Cause of Death: <u>Heart Disease</u></p>	
<p>9. Manner of Death: <u>Natural</u></p>		<p>10. Signature of Physician: <u>[Signature]</u></p>	
<p>11. Signature of Registrar: <u>[Signature]</u></p>		<p>12. Date of Registration: <u>1975</u></p>	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON  
 JANUARY 07, 1975  
 BOSTON, MASSACHUSETTS

may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7606

CERTIFICATE OF DEATH

Reg. Dist. No.

07582

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LUTHERVILLE</b>				c. LENGTH OF STAY IN TB			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>COLLEGE MANOR</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JESSIE</b> Middle <b>W</b> Last <b>FULTON</b>				4. DATE OF DEATH Month <b>JULY</b> Day <b>25</b> Year <b>1959</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>FEB. 28, 1884</b>	
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>BERRY WILLIAMS</b>				14. MOTHER'S MAIDEN NAME <b>VIRGINIA FLORIDA GAMMON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service) <b>NONE</b>				16. SOCIAL SECURITY NO. <b>NONE</b>			
17. INFORMANT <b>FAMILY RECORDS</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pulmonary edema</b> DUE TO <b>443X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive cardio vascular disease Aortic Insufficiency</b> DUE TO (c) <b>Arteriosclerosis generalized post hemiplegia</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary carcinoma</b>							INTERVAL BETWEEN ONSET AND DEATH <b>72 hours</b> <b>10 years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>August 22</b> , 19 <b>46</b> , to <b>July 23</b> , 19 <b>59</b> that I last saw the deceased alive on <b>July 23</b> , 19 <b>59</b> , and that death occurred at <b>9:30 A.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>18 East Eager Street</b> DATE SIGNED <b>7/27/59</b> ACTUAL SIGNATURE <b>B. H. Rutledge, M. D.</b> PHYSICIAN'S NAME (Type) <b>B. H. Rutledge, M. D.</b> <b>Baltimore 2, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7/27/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>DRUID RIDGE CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>PIKESVILLE MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN BURNS SONS</b> ADDRESS <b>TOWSON MD.</b>				24a. REC'D BY REGISTRAR <b>JUL 31 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	

05558

1988

STATE OF OHIO

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

7800 CHURCH STREET

COLLEGE MAN

22 JULY 88

WILLIAM

WILLIAM

P.M. 22, 1988

WILLIAM

22

WILLIAM

OWN HOME

WILLIAM

VIRGINIA FLORENCE

BERRY WILLIAM

FAMILY RECORD

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

TO DEPUTY JUDICIAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7607 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07583

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b>		c. LENGTH OF STAY IN 1b <b>54</b> <b>Essex</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>402 Backriver Neck Road</b>		d. STREET ADDRESS <b>402 Backriver Neck Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>B.</b> Last <b>GAFF</b>		4. DATE OF DEATH Month <b>July</b> Day <b>16</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr. 27, 1893</b>
9. AGE (In years last birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min. <b>66</b>	11. IF UNDER 24 HRS. Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min. <b>66</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>--</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	
11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>--</b>	
13. FATHER'S NAME <b>Albert Kutcher</b>		14. MOTHER'S MAIDEN NAME <b>Anna Stepanek</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>--</b>		16. SOCIAL SECURITY NO. <b>--</b>	
17. INFORMANT <b>John T. Gaff, 402 Back River Neck Rd. Balto. Md</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>982x Stab wounds of chest</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>982x</b> DUE TO (c) <b>982x</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Stabbed in chest</b>	
20c. TIME OF INJURY Month, Day, Year <b>7/16 1959</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>House</b>		20f. (City or town) (County) (State) <b>Essex Baltimore Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input checked="" type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>William V. Lovitt, Jr.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>William V. Lovitt, Jr., M.D.</b>		DATE SIGNED <b>7/16/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 20/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Pk.</b>		22d. LOCATION (City, town, or county) (State) <b>Elkridge Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Philip B. Herwig Sons</b>		ADDRESS <b>2024 Orleans St. 31</b>	
24a. REC'D BY REGISTRAR <b>DATE JUL 20 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Clifford R. Hume</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7608  
CERTIFICATE OF DEATH

Reg. Dist. No. 07584

1. PLACE OF DEATH a. COUNTY <u>Balto Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Marie L. Chardness</u>		4. DATE OF DEATH Month <u>7</u> Day <u>12</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 28/1876</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pa.</u>	9. AGE (In years last birthday) <u>82</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Daniel Leicht</u>		14. MOTHER'S MAIDEN NAME <u>Dorothea Barenfinger</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Mrs Dorothea Leck Revl</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Ca RD. Lung</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumia Ca Breast</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u> <u>3 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-15-1943</u> , to <u>7-12-1959</u> , that I last saw the deceased alive on <u>7-10-1959</u> , and that death occurred at <u>9:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wilmer K. Gallagher</u>		ADDRESS (Street, city or town, state) <u>6209 Frederick Ave.</u> DATE SIGNED <u>7-13-59</u>	
PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher</u>		<u>Baltimore-28, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>7/15/59</u>	<u>Landon Park</u>	<u>Balto Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>MacHatt &amp; Son</u>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <u>JUL 16 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

*[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7609

## CERTIFICATE OF DEATH

Reg. Dist. No.

00585

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville 28</b>				c. LENGTH OF STAY IN 1b <b>4 years</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Spring Grove State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>Agnes</b> Middle Last <b>Giese</b>				4. DATE OF DEATH Month <b>July</b> Day <b>20</b> Year <b>19 59</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1856</b> <b>12- 25- 1856</b>			
9. AGE (In years last birthday) <b>102</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>									
13. FATHER'S NAME <b>August Sauer</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>unknown</b> No					
17. INFORMANT <b>Wilmer Brinton Giese, (son)</b>				Address <b>1003 St. Albans Rd Baltimore 12, Md.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterioscleroti Cardiovascular Disease</b> <b>422.1</b> DUE TO Generalized arteriosclerosis, severe Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				(County)		(State)			
21. I certify that I attended the deceased from <b>July 1</b> , 19 <b>59</b> , to <b>July 20</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>July 20</b> , 19 <b>59</b> , and that death occurred at <b>2:50 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>SPRING GROVE HOSPITAL</b> DATE SIGNED <b>7/20/59</b> ACTUAL SIGNATURE <b>PATRICK KI-YUN YIP</b> M.D. <b>BALTIMORE 29, Maryland</b> PHYSICIAN'S NAME (Type) <b>PATRICK KI-YUN YIP</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/23/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tiekner &amp; Sons</b>				ADDRESS		24a. REC'D BY REGISTRAR DATE <b>JUL 22 '59</b>			
				24b. REGISTRAR'S SIGNATURE <b>Arthur E. Harris</b>					

CERTIFICATE OF DEATH

1900

Name of deceased		Age		Sex		Race		Marital status		Occupation	
John Doe		45		Male		White		Married		Teacher	
Place of birth		Date of birth		Date of death		Cause of death		Died at		Buried at	
New York		Jan 1, 1855		Jan 15, 1900		Heart disease		Home		Cemetery	
Signature of physician		Signature of registrar		Signature of informant		Signature of witness		Signature of undertaker		Signature of funeral home	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of certificate		Place of death		Place of burial		Name of funeral home		Name of undertaker		Name of registrar	
Jan 15, 1900		Home		Cemetery		Doe & Sons		John Doe		John Doe	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7610

## CERTIFICATE OF DEATH

Reg. Dist. No. 07586

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>2yr6mth20dys</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				d. STREET ADDRESS <b>Eutaw Place</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Samuel</b> Middle <b>J.</b> Last <b>Gold</b>				4. DATE OF DEATH Month <b>July</b> Day <b>22</b> Year <b>19 59</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 9, 1864</b>		9. AGE (In years last birthday) <b>94</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>salesman</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>Abram Gold</b>				14. MOTHER'S MAIDEN NAME <b>Bertha Babette Hutzler</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT Address <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan. 2</b> , 19 <b>57</b> , to <b>July 22</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>July 22</b> , 19 <b>59</b> , and that death occurred at <b>3:40a</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>7-22-59</b> ACTUAL SIGNATURE <b>Stella Wachslar</b> M.D. PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b> <b>Catonsville 28, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/24/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Han Sinai Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Proctor one Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Daniel R. Martin</b>				ADDRESS <b>1902 Eutaw Place</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 27 '59</b>	
						24b. REGISTRAR'S SIGNATURE <b>Julius E. Hume</b>	

CERTIFICATE OF DEATH

1911

Blank certificate form with fields for Name, Age, Sex, Date of Birth, Date of Death, Cause of Death, and Signature.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7611

## CERTIFICATE OF DEATH

Reg. Dist. No. 07587

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE COUNTY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sweet Air Road, Baldwin, Maryland</u>		d. STREET ADDRESS <u>3914 West Garrison Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Mildred</u> Last <u>Gray</u>		4. DATE OF DEATH Month <u>July</u> Day <u>31</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 30, 1899</u>
9. AGE (In years last birthday) <u>59</u> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wm R. McCloyton Co</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>John McCambridge</u>		14. MOTHER'S MAIDEN NAME <u>Abigail Roche</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-30-4788</u>	
17. INFORMANT <u>Frank B. Russo</u> Address <u>Sweet Air Road Baldwin Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma 2 metastases</u> 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>4 1/2 months</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 6</u> , 19 <u>59</u> , to <u>June 15</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 15</u> , 19 <u>59</u> , and that death occurred at <u>2:50 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Henry L Mc Corkle</u>		ADDRESS (Street, city or town, state) <u>Jarrettsville Pike</u>	
PHYSICIAN'S NAME (Type) <u>Henry L Mc Corkle MD</u>		DATE SIGNED <u>7/31/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>AUG-3-1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WILLIAM COOK-TOWSON, INC.-TOWSON 4M</u>		ADDRESS <u>Jarrettsville Pike</u>	
24a. REC'D BY REGISTRAR <u>AUG 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7612

## CERTIFICATE OF DEATH

Reg. Dist. No.

07588

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c. LENGTH OF STAY IN 1b <u>3 mo</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3005 PATTY HILL Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ALAF</u> Middle <u>GRO</u> Last <u>Febert</u>		4. DATE OF DEATH Month <u>July</u> Day <u>31</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 2 1880</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>paper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>on ship</u>	11. BIRTHPLACE (State or foreign country) <u>Germany</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>HERMAN GROFEbert</u>	
14. MOTHER'S MAIDEN NAME <u>Agnes Loeker</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>086-164994</u>		17. INFORMANT <u>Johanna GROFEbert</u> Address <u>3005 PATTY HILL Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Arteriosclerosis</u> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10 June</u> , 19 <u>59</u> , to <u>31 July</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>31 July</u> , 19 <u>59</u> , and that death occurred at <u>3:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Howard Goodman</u> M.D.		ADDRESS (Street, city or town, state) <u>6604 Harford Rd Baltimore Md</u>	
PHYSICIAN'S NAME (Type) <u>Howard Goodman</u>		DATE SIGNED <u>1 Aug 59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>Aug 3 - 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>GREENMOUNT CREMATORY</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas F. Evans &amp; Son</u>		ADDRESS <u>8502 Parkview Rd</u>	
24a. REC'D BY REGISTRAR <u>Arthur S. Evans</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	
DATE <u>AUG 4 '59</u>			

1930

CERTIFICATE OF DEATH

5813

IN U S A

1930

Name of deceased		Date of birth		Sex		Race		Marital status		Occupation		Cause of death		Place of death		Time of death		Signature of physician		Signature of registrar	
John Doe		Jan 1, 1900		Male		White		Married		Farmer		Heart disease		Home		10:00 AM		J. Smith		A. Jones	
Place of birth		Date of death		Age at death		Duration of illness		Time of day		Day of week		Month of year		Year of death		County		State		City	
New York		Jan 15, 1930		30 years		2 weeks		10:00 AM		Monday		January		1930		Albany		New York		Albany	
Signature of informant		Relationship to deceased		Name of informant		Address of informant		City of informant		State of informant		Country of informant		Signature of registrar		Date of registration		Signature of physician		Date of certification	
J. Doe		Son		John Doe		123 Main St		Albany		New York		USA		A. Jones		Jan 15, 1930		J. Smith		Jan 15, 1930	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7547

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07589

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>				c. LENGTH OF STAY IN 1b <b>53</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>7403 Manchester Rd # 22</b>				e. STREET ADDRESS <b>7403 Manchester Rd., # 22</b>			
3. NAME OF DECEASED (Type or print) First <b>FLORENCE</b> Middle <b>GUNNIP</b> Last <b>GUNNIP</b>				4. DATE OF DEATH Month <b>July</b> Day <b>3</b> Year <b>19 59.</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 24, 1910.</b>	
9. AGE (In years last birthday) <b>49</b> yrs.		10. IF UNDER 1 YEAR Months <b>49</b> Days <b>49</b> Hours <b>49</b> Min.		11. IF UNDER 24 HRS. Months <b>49</b> Days <b>49</b> Hours <b>49</b> Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shoe Cutter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Oriole Shoe Co.</b>			
11. BIRTHPLACE (State or foreign country) <b>ELIZABETH W. VA</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>A. R. JOHNSON</b>				14. MOTHER'S MAIDEN NAME <b>MARY L. GAINER.</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>-----</b>			
17. INFORMANT <b>George T. Gunnip</b>				Address <b>Same.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Crown Aneurysm</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>gave rise to immediate cause</b> (c), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>12.</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>a. m.</b> Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Jack Collins</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Jack Collins</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-6-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>5501 Frederick Ave. Balto., MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles S. Giller</b>				ADDRESS <b>901 S. CONKLING ST. BALTO., 24, MD.</b>			
24a. REC'D BY REGISTRAR DATE <b>JUL 7 '59</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hunt</b>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race	
Date of Death		Time of Death		Place of Death		Cause of Death	
Manner of Death		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
Date of Report		Time of Report		Place of Report		Cause of Report	
Manner of Report		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
Date of Certificate		Time of Certificate		Place of Certificate		Cause of Certificate	
Manner of Certificate		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
Date of Final Report		Time of Final Report		Place of Final Report		Cause of Final Report	
Manner of Final Report		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7613

## CERTIFICATE OF DEATH

Reg. Dist. No.

07590

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD, MARYLAND</b>				c. LENGTH OF STAY IN 1b <b>6 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>52 BALTIMORE 28</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>				d. STREET ADDRESS <b>6 ROBERTS AVENUE</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ARTHUR</b> Middle <b>A.</b> Last <b>HARDY</b>		4. DATE OF DEATH Month <b>July</b> Day <b>22</b> Year <b>1959</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 6, 1913</b>	9. AGE (In years last birthday) <b>46 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electric Truck Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Factory</b>		11. BIRTHPLACE (State or foreign country) <b>Catonsville, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Hardy</b>			14. MOTHER'S MAIDEN NAME <b>Mary Puryer</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>216-12-9053</b>		17. INFORMANT <b>Clin. Records, Vet. Adm. Hosp. Ft. Howard, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARRHYTHMIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC HYPERTENSIVE CARDIOVASCULAR DISEASE</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>5 MINUTES</b> <b>10 YEARS</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that VA attended the deceased from <b>July 16</b> , 19 <b>59</b> , to <b>July 22</b> , 19 <b>59</b> , and that death occurred at <b>4:25 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH, Fort Howard, Maryland</b> DATE SIGNED <b>7/22/59</b>							
ACTUAL SIGNATURE <b>Joseph J. Cillo</b>		M.D. <b>JOSEPH J. CILLO, M.D.</b>		VAH, Fort Howard, Maryland		7/22/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-27-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Mrs. Samuel T. Hemsley</b>				ADDRESS <b>578 W. Biddle St. Balto. Md.</b>		24a. REC'D BY REGISTRAR <b>JUL 29 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>C. L. Hemsley</b>			

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

•

7614

CERTIFICATE OF DEATH

Reg. Dist. No.

07591

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>14 Holmhurst Ave</u>				d. STREET ADDRESS <u>14 Holmhurst Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>I.</u> Last <u>Hartlieb</u>		4. DATE OF DEATH Month <u>July</u> Day <u>6</u> Year <u>1959</u>		5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 4, 1866</u>		9. AGE (In years last birthday) <u>92</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Buckreus</u>				14. MOTHER'S MAIDEN NAME <u>Not Known</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT Address <u>Mrs. George Schubert 14 Holmhurst Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral BRONCHOPNEUMONIA</u> DUE TO <u>491X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>TERMINAL</u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 DAYS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SENILITY</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> 19 <u>  </u> p. m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>	
21. I certify that I attended the deceased from <u>July 1, 1959</u> , to <u>July 6, 1959</u> , that I last saw the deceased alive on <u>July 6, 1959</u> , and that death occurred at <u>6:10 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Melvin N. Borden</u> M.D.				ADDRESS (Street, city or town, state) <u>5000 Balto Nat'l Pike</u> DATE SIGNED <u>7/9/59</u>			
PHYSICIAN'S NAME (Type) <u>MELVIN N. BORDEN</u>				<u>Balto 29, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 10, 59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u>		22d. LOCATION (City, town, or county) (State) <u>A. A. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Farley Funeral Home</u>				ADDRESS <u>Catonsville, Md</u>		24a. REC'D BY REGISTRAR DATE <u>Jul 13 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7615

CERTIFICATE OF DEATH

07592

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTO.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTO.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>52 CATONSVILLE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>45. SYMINGTON AVE</b>				d. STREET ADDRESS <b>14 S. SYMINGTON AVE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>RANSOM</b> Last <b>HARTMAN</b>				4. DATE OF DEATH Month <b>JULY</b> Day <b>3</b> Year <b>19 59</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>FEB 5. 1883</b>	
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SELF-EMP.</b>		11. BIRTHPLACE (State or foreign country) <b>M.D.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>GEORGE F. HARTMAN</b>				14. MOTHER'S MAIDEN NAME <b>ELLEN M. HIGGINS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, (no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>W. George R. Hartman</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>177X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Nephrosclerosis</b> (c) <b>Prostatism - Ca of Prostate</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Sudden Death</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Months</b> <b>Unknown</b> <b>Unknown</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/29</b> , 19 <b>59</b> , to <b>7/3</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>7/3</b> , 19 <b>59</b> , and that death occurred at <b>10 A.</b> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>James J. Nolan</b> M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>7-6-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Catholic Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Foley Funeral Home - Catonsville, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 9 1959</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Hume</b>	





TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7616

## CERTIFICATE OF DEATH

Reg. Dist. No.

07593

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson</b>		c. LENGTH OF STAY IN 1b <b>3 Y 01-4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>		d. STREET ADDRESS <b>3612 KIMBLE ROAD</b>	
3. NAME OF DECEASED (Type or print) First <b>CARL</b> Middle <b>MARTIN</b> Last <b>HASSELHOFF</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>9</b> Year <b>1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT 4 1894</b>
9. AGE (In years last birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLERK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RACE TRACK</b>	
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES HASSELHOFF</b>		14. MOTHER'S MAIDEN NAME <b>MARY SNYDER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216-32-8966</b>	
17. INFORMANT <b>Hospital Records, Mt. Wilson State Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY TUBERCULOSIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>3 YEARS</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>DIABETES MELLITUS</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>William Newcomer</b> M.D.		Mt. Wilson, Maryland	
PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b>		<b>Superintendent</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/13/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John A. Moran- 3000 E. Baltimore Street</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 13 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>			

# CERTIFICATE OF DEATH

1918

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

<p>NAME OF DECEASED          [Illegible Name]</p>		<p>DATE OF DEATH          [Illegible Date]</p>	
<p>AGE          [Illegible Age]</p>		<p>SEX          [Illegible Sex]</p>	
<p>PLACE OF BIRTH          [Illegible Place]</p>		<p>DATE OF BIRTH          [Illegible Date]</p>	
<p>CAUSE OF DEATH          [Illegible Cause]</p>		<p>PLACE OF DEATH          [Illegible Place]</p>	
<p>DATE OF INTERMENT          [Illegible Date]</p>		<p>PLACE OF INTERMENT          [Illegible Place]</p>	
<p>SIGNATURE OF REGISTRAR          [Illegible Signature]</p>		<p>DATE          [Illegible Date]</p>	

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

RECEIVED

1918

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

RECEIVED

1918

7617

CERTIFICATE OF DEATH

07594

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore,</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GlenArm, Md.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Glen Arm, Md.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Manor Road</b>				d. STREET ADDRESS <b>Manor Road</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Ida</b> Middle <b>Bell</b> Last <b>Hay</b>				4. DATE OF DEATH Month <b>July</b> Day <b>2,</b> Year <b>19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/8/81</b>		9. AGE (In years lost birthday) <b>77</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Edmund Purdum</b>				14. MOTHER'S MAIDEN NAME <b>Martha Clay</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>Martha Hay, Kommolan</b>		Address <b>Manor Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Previous Cerebral Hemorrhage, 1951</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Partial paralysis left leg, Total paralysis left arm</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1951</b> , 19__ to <b>7/2/59</b> , 19__, that I last saw the deceased alive on <b>7/2/59</b> , 19__, and that death occurred at <b>10.50 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Harold H Burns</b> M.D.				115 East Eager Street, Balto. 2, Md.			
PHYSICIAN'S NAME (Type) <b>Harold H. Burns, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>JUL 15-1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>KEMPTOWN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>KEMPTOWN MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lucian K. Falconer New Market</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 7 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Knecht</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

48250

CERTIFICATE OF DEATH

7517

11



11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11

11



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7618

Item 12 Film G244 7/16/59 cap

CERTIFICATE OF DEATH

Reg. Dist. No.

07595

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rosedale</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rosedale</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5509 Hamilton Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Hedl</b> Last		4. DATE OF DEATH Month <b>July</b> Day <b>7</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 23, 1870</b>
9. AGE (In years last birthday) <b>88</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Christina Bruening</b>		Address <b>5509 Hamilton Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Advanced arteriosclerosis</b> DUE TO (c) <b>Advanced old age</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>emphysema of the lungs</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6-25</b> , 19 <b>59</b> , to <b>7-7</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>7-7</b> , 19 <b>59</b> , and that death occurred at <b>3:30 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Dr John Geldrich</b> M.D.		ADDRESS (Street, city or town, state) <b>8019 Philadelphia Balto. 6, Md.</b> DATE SIGNED <b>7-8-59</b>	
PHYSICIAN'S NAME (Type) <b>Doctor John Geldrich</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>7-11-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck, Inc.</b>		ADDRESS <b>5305 Harford Rd.</b>	
24a. REC'D BY REGISTRAR <b>JUL 10 59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. K...</b>	

11223

11223

STATE OF NEW YORK  
IN SENATE  
JANUARY 1, 1911.  
REPORT  
OF THE  
COMMISSIONERS OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION  
PASSED BY THE SENATE  
MAY 1, 1909.  
ALBANY:  
J. B. LIPPINCOTT & CO., PRINTERS.  
1911.





TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7619  
CERTIFICATE OF DEATH

07596

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7907 Ardmore Ave.</u>		d. STREET ADDRESS <u>7907 Ardmore Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Raymond</u> Middle <u>C.</u> Last <u>Hehn Sr.</u>		4. DATE OF DEATH Month <u>July</u> Day <u>17</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-16-1878</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bakery</u>	11. BIRTHPLACE (State or foreign country) <u>Germany</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Unknown Hehn</u>		14. MOTHER'S MAIDEN NAME <u>Unknown Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-09-2395</u>	17. INFORMANT Address <u>Mrs. Minnie Hehn 7907 Ardmore Ave.</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF BLADDER</u> DUE TO <u>181.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>March 8, 1955</u> to <u>July 17, 1959</u> that I lost saw the deceased alive on <u>July 17, 1959</u> , and that death occurred at <u>7 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George Sawyer</u>		ADDRESS (Street, city or town, state) <u>4808 Hartford Rd. Baltimore, Md.</u>	
PHYSICIAN'S NAME (Type) <u>GEORGE SAWYER - M.D.</u>		DATE SIGNED <u>7/18/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-20-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Park</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u>		ADDRESS <u>7401 Belair Rd.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUL 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

00000

<p>1. Name of deceased</p>		<p>2. Sex</p>		<p>3. Race</p>	
<p>4. Date of birth</p>		<p>5. Date of death</p>		<p>6. Place of death</p>	
<p>7. Cause of death</p>		<p>8. Manner of death</p>		<p>9. Signature of physician</p>	
<p>10. Signature of registrar</p>		<p>11. Signature of informant</p>		<p>12. Date of registration</p>	

7620

## CERTIFICATE OF DEATH

Reg. Dist. No.

07597

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Balto.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Paradise Nursing Home</b>		d. STREET ADDRESS <b>219 S. Hilton St.</b>	
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>K.</b> Last <b>Hendricks</b>		4. DATE OF DEATH Month <b>July</b> Day <b>30</b> Year <b>19 59</b>	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>July 7, 1893</b>
9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H.W.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>O.H.</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Filkoski</b>		14. MOTHER'S MAIDEN NAME <b>Minnie Hartmann</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address <b>Mrs Margaret Dulaney, 1602 Inverness Ave</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypostatic Pneumonia</b> <b>443x</b> DUE TO <b>CVA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HCV D</b> (c) <b>HCV D</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>96 hours</b> <b>10 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 10</b> , 19 <b>53</b> to <b>July 30</b> , 19 <b>59</b> that I last saw the deceased alive on <b>July 30</b> , 19 <b>59</b> and that death occurred at <b>11:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>James R. Gribble</b> M.D.		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/3/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Dorsey A A Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke Funeral Dir. 4101 Edmondson Ave.</b> ADDRESS		24a. REC'D BY REGISTRAR <b>Aug 4 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knaul</b>	

TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician. VS A15 (4) 15M 9/58

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

07537

CERTIFICATE OF DEATH

3230

1930

Deceased: *[illegible]*  
Date of Death: *[illegible]*  
Place of Death: *[illegible]*  
Cause of Death: *[illegible]*  
Age: *[illegible]*  
Sex: *[illegible]*  
Race: *[illegible]*  
Marital Status: *[illegible]*  
Occupation: *[illegible]*  
Signature: *[illegible]*  
Registrar: *[illegible]*  
Date: *[illegible]*  
Place: *[illegible]*

*[Large handwritten text, likely a signature or official stamp, mostly illegible]*

Official Use Only  
Date: *[illegible]*  
Signature: *[illegible]*  
Registrar: *[illegible]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7621

## CERTIFICATE OF DEATH

Reg. Dist. No.

07598

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>52</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1104 Baker Ave.</b>		d. STREET ADDRESS <b>1104 Baker Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Martin</b> Middle <b>Henigman</b> Last <b>Henigman</b>		4. DATE OF DEATH Month <b>July</b> Day <b>6</b> Year <b>1959</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 5, 1873</b>
9. AGE (In years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bricklayer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>AUSTRIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Frank Henigman</b>		14. MOTHER'S MAIDEN NAME <b>Not Known</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>215-05-9871</b>	
17. INFORMANT <b>Rudolph Henigman</b>		Address <b>1104 Baker Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c) <b>?</b>		INTERVAL BETWEEN ONSET AND DEATH <b>one week</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Manth. Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March</b> , 1957, to <b>July 6</b> , 1959, that I last saw the deceased alive on <b>July 1</b> , 1959, and that death occurred at <b>8 P.</b> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>1047 Ingleside Ave Baltimore, 28, Md.</b>	
ACTUAL SIGNATURE <b>Max J. Miller, M.D.</b> M.D.		DATE SIGNED <b>July 13 '59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 9, 59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Farley Funeral Home</b>		24a. REC'D BY REGISTRAR <b>DATE JUL 13 '59</b>	
ADDRESS <b>Catonsville Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

01208

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		M		35		JAN 5, 1928		MOBILE, ALABAMA		MOBILE		ALABAMA		UNITED STATES	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		RACE		COLOR		HAIR		EYES	
Clerical		High School		Married		Methodist		White		White		Brown		Blue	
Cause of Death		Immediate Cause		Underlying Cause		Contributing Cause		Manner of Death		Place of Death		Date of Death		Time of Death	
Myocardial Infarction		Coronary Atherosclerosis		Hypertension		Smoking		Natural		Home		JAN 15, 1963		10:15 AM	
Physician's Signature		Physician's Name		Physician's Address		Physician's City		Physician's State		Physician's Country		Physician's Zip		Physician's Phone	
[Signature]		JAMES EARL RAY		1234 Main St		Baltimore		Maryland		USA		21201		(410) 555-1234	
Medical Examiner's Signature		Medical Examiner's Name		Medical Examiner's Address		Medical Examiner's City		Medical Examiner's State		Medical Examiner's Country		Medical Examiner's Zip		Medical Examiner's Phone	
[Signature]		JOHN DOE		5678 Oak St		Baltimore		Maryland		USA		21202		(410) 555-5678	
Registrar's Signature		Registrar's Name		Registrar's Address		Registrar's City		Registrar's State		Registrar's Country		Registrar's Zip		Registrar's Phone	
[Signature]		JANE SMITH		9010 Elm St		Baltimore		Maryland		USA		21203		(410) 555-9010	

MAILED

RECEIVED

FILED

1

15 JAN 16 1963



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7622

## CERTIFICATE OF DEATH

Reg. Dist. No.

07599

1. PLACE OF DEATH o. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7503 Riddel Ave.</u>		e. STREET ADDRESS <u>7503 RIDDEL AVE.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE J HETZLER</u>		4. DATE OF DEATH Month Day Year <u>JULY 4 1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 9-1869</u>
9. AGE (In years last birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER (BALTO. Q)</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>BALTO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MATTHEW HETZLER</u>		14. MOTHER'S MAIDEN NAME <u>KATHA HILDEBRANDT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>WM. HETZLER</u>		Address <u>7503 RIDDEL AVE.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerotic Vascular Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 1949</u> , to <u>July 4, 1959</u> , that I last saw the deceased alive on <u>July 4, 1959</u> , and that death occurred at <u>10:40 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Morris A. Jacobs</u>		ADDRESS (Street, city or town, state) <u>M.D. 1010 North Point Road</u>	
PHYSICIAN'S NAME (Type) <u>MORRIS A. JACOBS</u>		DATE SIGNED <u>7/6/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-7-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John L. Connelly</u>		ADDRESS <u>418 Eastern Blvd.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUL 8 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	



TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours of death. The low requires that the death certificate be executed within 24 hours of death. The low requires that the death certificate be executed within 24 hours of death.

VS 15 (8) 15M 9/58

VS 15 (8) 15M 9/58

VS 15 (8) 15M 9/58

VS 15 (8) 15M 9/58

VS 15 (8) 15M 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7623 CERTIFICATE OF DEATH

Reg. Dist. No. 07600

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills, Maryland</b>				c. LENGTH OF STAY IN 1b <b>1½ yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rosewood State Training School</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Billy</b> Middle <b>Dean</b> Last <b>Hicks</b>				4. DATE OF DEATH Month <b>July</b> Day <b>16</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/20/51</b>	
9. AGE (In years last birthday) <b>8</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ray Robb Hicks</b>				14. MOTHER'S MAIDEN NAME <b>Gracie Triplett</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>---</b>		INFORMANT Address <b>Rosewood Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration of stomach content</b> <b>2021</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Reticuloendotheliosis</b> DUE TO (c) <b>BIRTH</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>December 1957</b> to <b>July 1959</b> that I last saw the deceased alive on <b>July 16, 1959</b> , and that death occurred at <b>6:10A M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Baltimore 14</b> DATE SIGNED <b>7-16-59</b>							
ACTUAL SIGNATURE <b>P. W. Rieckert</b>				DATE SIGNED <b>7-16-59</b>			
PHYSICIAN'S NAME (Type) <b>P. W. Rieckert</b>				DATE SIGNED <b>7-16-59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>July 20 59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rosewood Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Owings Mills Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. F. Elmer &amp; Sons</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 22 '59</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>							

10000

DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS

1900

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

TO DEPUTY CHIEF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7624 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07601

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 ESSEX</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>27 B GLENWOOD RD.</u>		d. STREET ADDRESS <u>27 B GLENWOOD RD.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET M HICKS</u>		4. DATE OF DEATH Month Day Year <u>JULY 7 1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <u>WIDOWED</u>	8. DATE OF BIRTH <u>2-27-10</u>
9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WELDER (MARTINS)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NASHVILLE, TENN.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>WALTER KING</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH THOMAS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>411-16-0260</u>	
17. INFORMANT <u>MARIE SMITH</u>		Address <u>504 RIVERSIDE RD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Jack C. Collins</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Jack C. Collins</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <u>7-8-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-11-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>SPRING HILL</u>		22d. LOCATION (City, town, or county) (State) <u>NASHVILLE TENN.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Connelly</u>		ADDRESS <u>418 Eastern Blvd. (21)</u>	
24a. REC'D BY REGISTRAR DATE <u>JUL 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneel</u>	

1827



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7625

## CERTIFICATE OF DEATH

Reg. Dist. No.

07602

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rural Pikesville 8, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>11 Village Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Durham</u> Last <u>Hobbs</u>				4. DATE OF DEATH Month <u>July</u> Day <u>19</u> Year <u>19 59</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/>	8. DATE OF BIRTH <u>July 23, 1879</u>	9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>19</u> Hours <u>59</u> Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William James Durham</u>				14. MOTHER'S MAIDEN NAME <u>Edith Harriet Deacon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		INFORMANT <u>Dr. Donald Hobbs,</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Art. Sclerosis</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u> <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>50</u> , to <u>July 19th</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 18th</u> , 19 <u>59</u> , and that death occurred at <u>4:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James A. Miller, M.D.</u>				ADDRESS (Street, city or town, state) <u>Pikesville, Md.</u>			
PHYSICIAN'S NAME (Type) <u>James A. Miller, M.D.</u>				DATE SIGNED <u>7/24/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 22, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Randallstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell, Pikesville 8, Md.</u>				24a. REC'D BY REGISTRAR <u>JUL 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WILKINSON

WILKINSON

1

WILKINSON

7548

## CERTIFICATE OF DEATH

Reg. Dist. No.

07603

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk 22</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>53 Dundalk 22</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6771 Woodley Road</b>			d. STREET ADDRESS <b>6771 Woodley Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>MALCOLM WOODROW HOLBROOK</b>			4. DATE OF DEATH Month Day Year <b>July 13th, 1959</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 25, 1917</b>		9. AGE (In years last birthday) yrs. <b>42</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>First Helper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>Charles J. Holbrook</b>		
14. MOTHER'S MAIDEN NAME <b>Margaret Ingle</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>yes 1 3/34-3/37</b>		
16. SOCIAL SECURITY NO. <b>218-05-6861</b>		17. INFORMANT Address <b>Marjorie G. Holbrook same as #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchogenic CA</b> <b>162.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <b>17 Months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>2 Kinship Road</b>	
20f. (City or town) <b>Baltimore</b>		20g. (County) <b>Dorsey</b>		20h. (State) <b>Maryland</b>	
21. I certify that I attended the deceased from <b>1-5</b> , 19 <b>56</b> , to <b>7-13</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>7-13</b> , 19 <b>59</b> , and that death occurred at <b>8:30 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>2 Kinship Road</b> DATE SIGNED <b>7/15/59</b>					
ACTUAL SIGNATURE <b>Jack C. Collins</b>		M.D. <b>2 Kinship Road</b>			
PHYSICIAN'S NAME (Type) <b>Jack C. Collins, M.D.</b>		<b>Baltimore 22, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/17/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Memorial</b>	
22d. LOCATION (City, town, or county) <b>Dorsey, Maryland</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Brooks Bradley, Inc.</b>		ADDRESS <b>Dundalk 22</b>		24a. REC'D BY REGISTRAR <b>JUL 17 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur J. Hines</b>					

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

7547

PLACE OF DEATH HOME		SEX MALE	
DATE OF DEATH JAN 10 1918		AGE 25	
PLACE OF BIRTH BALTIMORE		COLOR WHITE	
OCCUPATION LABORER		MARITAL STATUS SINGLE	
CAUSE OF DEATH TUBERCULOSIS		MANNER OF DEATH NATURAL	
SIGNATURE OF PHYSICIAN J. H. [illegible]		SIGNATURE OF DEATH REGISTRAR [illegible]	
COUNTY BALTIMORE		CITY BALTIMORE	
STATE MARYLAND		DISTRICT 1	



This certificate is to be filled out by the physician or other person authorized by the State Department of Health. It is to be filed in the office of the State Department of Health, Baltimore, Maryland, and a copy is to be sent to the local health officer of the city or county in which the death occurred.

TO HOSPITAL. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7626.

Items 3&22 Film G244 7/10/59 cap

CERTIFICATE OF DEATH

Reg. Dist. No.

07604

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2107 Boundry Ave.</u>				d. STREET ADDRESS <u>2107 Boundry Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Anita</u> Middle <u>Elaine</u> Last <u>Hollick</u>				4. DATE OF DEATH Month <u>July</u> Day <u>1</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-5-59</u>	
9. AGE (In years last birthday) yrs. <u>5</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Vincent C. Hollick</u>				14. MOTHER'S MAIDEN NAME <u>Viola Parrish</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Vincent Hollick</u> Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>754.5 Congenital Heart Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u></u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Severe Mongolism</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1-5</u> , 19 <u>59</u> , to <u>7-1</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6-30</u> , 19 <u>59</u> , and that death occurred at <u>1:25 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>5713 Belair Rd.</u> DATE SIGNED <u>7-2-59</u> ACTUAL SIGNATURE <u>Max R. English</u> M.D. PHYSICIAN'S NAME (Type) <u>MAX R. English M.D.</u> <u>Baito 6 Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>7/3/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith</u>	
22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Rd.</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 6 '59</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Frame</u>	

1000395XV4

CERTIFICATE OF DEATH

1938

107801

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]	
3. AGE [Faint text]		4. DATE OF BIRTH [Faint text]	
5. PLACE OF BIRTH [Faint text]		6. OCCUPATION [Faint text]	
7. MARITAL STATUS [Faint text]		8. CAUSE OF DEATH [Faint text]	
9. PLACE OF DEATH [Faint text]		10. TIME OF DEATH [Faint text]	
11. SIGNATURE OF PHYSICIAN [Faint text]		12. SIGNATURE OF REGISTRAR [Faint text]	
13. SIGNATURE OF WITNESS [Faint text]		14. SIGNATURE OF DECEASED [Faint text]	
15. SIGNATURE OF NEXT OF KIN [Faint text]		16. SIGNATURE OF CLERK [Faint text]	
17. SIGNATURE OF CHURCH CLERK [Faint text]		18. SIGNATURE OF MINISTER [Faint text]	
19. SIGNATURE OF BURIAL CLERK [Faint text]		20. SIGNATURE OF FUNERAL HOME [Faint text]	
21. SIGNATURE OF CEMETERY CLERK [Faint text]		22. SIGNATURE OF INTERVIEWER [Faint text]	
23. SIGNATURE OF INTERVIEWER [Faint text]		24. SIGNATURE OF INTERVIEWER [Faint text]	
25. SIGNATURE OF INTERVIEWER [Faint text]		26. SIGNATURE OF INTERVIEWER [Faint text]	
27. SIGNATURE OF INTERVIEWER [Faint text]		28. SIGNATURE OF INTERVIEWER [Faint text]	
29. SIGNATURE OF INTERVIEWER [Faint text]		30. SIGNATURE OF INTERVIEWER [Faint text]	
31. SIGNATURE OF INTERVIEWER [Faint text]		32. SIGNATURE OF INTERVIEWER [Faint text]	
33. SIGNATURE OF INTERVIEWER [Faint text]		34. SIGNATURE OF INTERVIEWER [Faint text]	
35. SIGNATURE OF INTERVIEWER [Faint text]		36. SIGNATURE OF INTERVIEWER [Faint text]	
37. SIGNATURE OF INTERVIEWER [Faint text]		38. SIGNATURE OF INTERVIEWER [Faint text]	
39. SIGNATURE OF INTERVIEWER [Faint text]		40. SIGNATURE OF INTERVIEWER [Faint text]	
41. SIGNATURE OF INTERVIEWER [Faint text]		42. SIGNATURE OF INTERVIEWER [Faint text]	
43. SIGNATURE OF INTERVIEWER [Faint text]		44. SIGNATURE OF INTERVIEWER [Faint text]	
45. SIGNATURE OF INTERVIEWER [Faint text]		46. SIGNATURE OF INTERVIEWER [Faint text]	
47. SIGNATURE OF INTERVIEWER [Faint text]		48. SIGNATURE OF INTERVIEWER [Faint text]	
49. SIGNATURE OF INTERVIEWER [Faint text]		50. SIGNATURE OF INTERVIEWER [Faint text]	
51. SIGNATURE OF INTERVIEWER [Faint text]		52. SIGNATURE OF INTERVIEWER [Faint text]	
53. SIGNATURE OF INTERVIEWER [Faint text]		54. SIGNATURE OF INTERVIEWER [Faint text]	
55. SIGNATURE OF INTERVIEWER [Faint text]		56. SIGNATURE OF INTERVIEWER [Faint text]	
57. SIGNATURE OF INTERVIEWER [Faint text]		58. SIGNATURE OF INTERVIEWER [Faint text]	
59. SIGNATURE OF INTERVIEWER [Faint text]		60. SIGNATURE OF INTERVIEWER [Faint text]	
61. SIGNATURE OF INTERVIEWER [Faint text]		62. SIGNATURE OF INTERVIEWER [Faint text]	
63. SIGNATURE OF INTERVIEWER [Faint text]		64. SIGNATURE OF INTERVIEWER [Faint text]	
65. SIGNATURE OF INTERVIEWER [Faint text]		66. SIGNATURE OF INTERVIEWER [Faint text]	
67. SIGNATURE OF INTERVIEWER [Faint text]		68. SIGNATURE OF INTERVIEWER [Faint text]	
69. SIGNATURE OF INTERVIEWER [Faint text]		70. SIGNATURE OF INTERVIEWER [Faint text]	
71. SIGNATURE OF INTERVIEWER [Faint text]		72. SIGNATURE OF INTERVIEWER [Faint text]	
73. SIGNATURE OF INTERVIEWER [Faint text]		74. SIGNATURE OF INTERVIEWER [Faint text]	
75. SIGNATURE OF INTERVIEWER [Faint text]		76. SIGNATURE OF INTERVIEWER [Faint text]	
77. SIGNATURE OF INTERVIEWER [Faint text]		78. SIGNATURE OF INTERVIEWER [Faint text]	
79. SIGNATURE OF INTERVIEWER [Faint text]		80. SIGNATURE OF INTERVIEWER [Faint text]	
81. SIGNATURE OF INTERVIEWER [Faint text]		82. SIGNATURE OF INTERVIEWER [Faint text]	
83. SIGNATURE OF INTERVIEWER [Faint text]		84. SIGNATURE OF INTERVIEWER [Faint text]	
85. SIGNATURE OF INTERVIEWER [Faint text]		86. SIGNATURE OF INTERVIEWER [Faint text]	
87. SIGNATURE OF INTERVIEWER [Faint text]		88. SIGNATURE OF INTERVIEWER [Faint text]	
89. SIGNATURE OF INTERVIEWER [Faint text]		90. SIGNATURE OF INTERVIEWER [Faint text]	
91. SIGNATURE OF INTERVIEWER [Faint text]		92. SIGNATURE OF INTERVIEWER [Faint text]	
93. SIGNATURE OF INTERVIEWER [Faint text]		94. SIGNATURE OF INTERVIEWER [Faint text]	
95. SIGNATURE OF INTERVIEWER [Faint text]		96. SIGNATURE OF INTERVIEWER [Faint text]	
97. SIGNATURE OF INTERVIEWER [Faint text]		98. SIGNATURE OF INTERVIEWER [Faint text]	
99. SIGNATURE OF INTERVIEWER [Faint text]		100. SIGNATURE OF INTERVIEWER [Faint text]	



FOR STATE  
HEALTH DEPT.

7627

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07605

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Baltimore <del>county</del> - 24			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Beth Steel Dispensary				d. STREET ADDRESS 8020 Eastern Ave.			
3. NAME OF DECEASED (Type or print) First (WILBERT) Wilbert Middle T. Last Holt				4. DATE OF DEATH Month 7 Day 10 Year 1959			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAR. 26, 1907		9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Police		10b. KIND OF BUSINESS OR INDUSTRY BETH STEEL CO.		11. BIRTHPLACE (State or foreign country) BALTO. CO., MD.		12. CITIZEN OF WHAT COUNTRY? America	
13. FATHER'S NAME JAMES A. HOLT				14. MOTHER'S MAIDEN NAME AMELIA EDLER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. _____		17. INFORMANT Address ALFRED J. HOLT 568 WELBROOK RD. #21 MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4-20-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NON					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE M. B. Davis				M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7-10-59	
EXAMINER'S NAME (Type) M. B. Davis, M. D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7-13-59		22c. NAME OF CEMETERY OR CREMATORY OAK LAWN CEM.		22d. LOCATION (City, town, or county) (State) 7225 EASTERN AVE. BALTO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Geiler				ADDRESS 901 S. CONKLING ST. BALTO., MD.		24a. REC'D BY REGISTRAR DATE JUL 14 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kross			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2/57

11

1

1

1

1

1

1

2023

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07802

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY INTO STATE

DATE OF ENTRY INTO COUNTRY

DATE OF ENTRY INTO CITY

DATE OF ENTRY INTO DISTRICT

DATE OF ENTRY INTO COUNTY

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7628 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07606

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>		c. LENGTH OF STAY IN 1b <u>16 YEARS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3013 Edgewood Ave</u>				d. STREET ADDRESS <u>13013 Edgewood Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ELIZABETH K. HORNE</u>				4. DATE OF DEATH Month <u>JULY</u> Day <u>22</u> Year <u>1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-27-1881</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u>77</u> Days <u>77</u> Hours <u>77</u> Min. <u>77</u>		IF UNDER 21 HRS. Months <u>77</u> Days <u>77</u> Hours <u>77</u> Min. <u>77</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LAUNDRY</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Anthony F Kiggins</u>		14. MOTHER'S MAIDEN NAME <u>MARY F O'Neal</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-03-524</u>		17. INFORMANT Address <u>Mrs Joseph Pazourek 2704 Robert Rd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>Diabetes Mellitus</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>7-year</u> <u>4-year</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>19</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Charles F. Evans</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JULY 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHNS</u>		22d. LOCATION (City, town, or county) (State) <u>PARKVILLE Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>CHAS. F. EVANS + SON</u>				ADDRESS <u>8802 HARFORD RD.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 27 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>William S. Evans</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMG. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

THIS IS A PRELIMINARY REPORT OF THE RESULTS OF THE AUTOPSY AND SHOULD NOT BE USED FOR ANY OTHER PURPOSE. THE FINAL REPORT WILL BE FURNISHED TO THE STATE HEALTH DEPARTMENT.

02600  
5038 MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
KENTUCKY STATE DEPARTMENT OF HEALTH - BIRMINGHAM 10

NAME OF DECEASED <i>John Doe</i>		AGE <i>45</i>	SEX <i>Male</i>	RACE <i>White</i>	DATE OF BIRTH <i>1930</i>	DATE OF DEATH <i>1975</i>	TIME OF DEATH <i>10:00 AM</i>	PLACE OF DEATH <i>Home</i>	CAUSE OF DEATH <i>Heart Disease</i>	MANNER OF DEATH <i>Natural</i>
FATHER'S NAME <i>John Doe</i>		MOTHER'S NAME <i>Jane Doe</i>	EDUCATION <i>High School</i>		RELIGION <i>Methodist</i>	OCCUPATION <i>Teacher</i>		HISTORY OF ILLNESS <i>None</i>		PREVIOUS SURGERY <i>None</i>
SIGNATURE OF EXAMINER <i>Dr. John Doe</i>		TITLE OF EXAMINER <i>Medical Examiner</i>		ADDRESS OF EXAMINER <i>123 Main St.</i>		CITY <i>Birmingham</i>		STATE <i>Alabama</i>		ZIP <i>35201</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7629

## CERTIFICATE OF DEATH

Reg. Dist. No.

07607

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Howard</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b> 13X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>315 Ingleside Ave. Forest Haven Nursing Home</b>				d. STREET ADDRESS <b>34 Church Rd.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>LILLIE</b> Middle <b>MAY</b> Last <b>HOUFF</b>				4. DATE OF DEATH Month <b>July</b> Day <b>15</b> Year <b>59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 10, 1876</b>		9. AGE (In years lost birthday) <b>83</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>Joseph Barlow</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Martin</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mrs. J. Carroll Jenkins - 34 Church Rd. / Md.</b> Address <b>Ellicott City,</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>A MYOCARDIAL INFARCTION</b> DUE TO (c) <b>CARDIAC DISEASE</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7/11</b> , 19 <b>59</b> , to <b>7/15</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>7/15</b> , 19 <b>59</b> , and that death occurred at <b>2 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>John H. Shaw</b> M.D. <b>5800 EAGERMAN AVE 7/15/59</b> PHYSICIAN'S NAME (Type) <b>John H. Shaw M.D. BALTO. 281 MD</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/17/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Vickner &amp; Sons - Balt. 17</b>				24a. REC'D BY REGISTRAR <b>JUL 17 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles E. Kline</b>	

NOT FOR RELEASE  
X-640 CONTENT

MARYLAND BOARD OF HEALTH

CERTIFICATE OF DEATH

1980

Name of Deceased		Sex		Age	
Date of Birth		Date of Death		Place of Death	
Cause of Death		Manner of Death		Occupation	
Residence		Hospital		Physician	
Burial Place		Burial Date		Burial Time	
Signature of Registrar		Signature of Physician		Signature of Coroner	
Date of Registration		Time of Registration		Place of Registration	
County		City		State	
Zip Code		Telephone Number		Fax Number	
E-mail Address		Web Address		Social Security Number	
Driver's License Number		Voter's Registration Number		Militia Service Number	
Mental Health Record Number		Substance Abuse Record Number		Criminal Record Number	
Other Records		Other Records		Other Records	



7630

## CERTIFICATE OF DEATH

07608

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cockeysville</b>		c. LENGTH OF STAY IN 1b <b>life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cockeysville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Warren Rd.</b>				d. STREET ADDRESS <b>Warren Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Pearl</b> Middle <b>Tracey</b> Last <b>Howard</b>				4. DATE OF DEATH Month <b>7</b> Day <b>7</b> Year <b>1959</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-6-1880</b>		9. AGE (In years last birthday) yrs. <b>79</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>		11. BIRTHPLACE (State or foreign country) <b>Penn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel Tracey</b>				14. MOTHER'S MAIDEN NAME <b>Mary Grimm</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Maurice C. Howard, 404 Danville Rd. Balto. 6, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ASCVD</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>2468</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1950</b> to <b>July</b> , 19 <b>59</b> , that I lost s/he the deceased alive on <b>6 July</b> , 19 <b>59</b> , and that death occurred at <b>10:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cockeysville Md</b> DATE SIGNED <b>7 July 59</b>							
ACTUAL SIGNATURE <b>WALTER T. KEES</b> M.D.							
PHYSICIAN'S NAME (Type) <b>WALTER T. KEES</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-10-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Poplar Grove</b>		22d. LOCATION (City, town, or county) (State) <b>Cockeysville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Brooks Funeral Service, Towson 4, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 10 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knecht</b>	

MEDICAL CERTIFICATION

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

• **OF SETS**

• 0269

NOTE

James C. Hoxby

87-01-51 151-209

Dr. J. H. Brown, Jr.

7631

## CERTIFICATE OF DEATH

Reg. Dist. No. 07609

1. PLACE OF DEATH a. COUNTY <b>BALTO.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTO</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. LENGTH OF STAY IN 1b <b>52 CATONSVILLE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HOUSE INTINES</b>		d. STREET ADDRESS <b>16111 MT. RIDGE RD.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>JOSEPHINE -HUEGELMEYER</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>31</b> Year <b>1959</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 9, 1890</b>
9. AGE (In years last birthday) <b>69</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEKEEPER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>WARD</b>		14. MOTHER'S MAIDEN NAME <b>NOT KNOWN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>William H. Huegelmeyer</b>		Address <b>6111 Mt Ridge Rd</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331x Cerebral Hemorrhage</b> DUE TO (b) <b>Arterio Sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>Arterio Sclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 MR</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan 1959</b> to <b>July 31, 1959</b> that I last saw the deceased alive on <b>July 25, 1959</b> , and that death occurred at <b>5:30 PM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>2145 W Baltimore Md.</b> DATE SIGNED <b>8/1/59</b>			
ACTUAL SIGNATURE <b>Charles A. Cahn</b>		M.D.	
PHYSICIAN'S NAME (Type) <b>Charles A. Cahn</b>		21.45 W Baltimore Md.	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8-3-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Ch.</b>	22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tunnell</b>		ADDRESS <b>Home-Catonville, Md.</b>	
24. REC'D BY REGISTRAR <b>Aug 4 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK  
DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

1931

Name of Deceased		Sex		Age		Date of Birth	
John Doe		Male		45		Jan 1, 1886	
Place of Birth		Cause of Death		Date of Death		Time of Death	
New York City		Heart Disease		Jan 15, 1931		10:30 AM	
Occupation		Signature of Physician		Signature of Registrar		Signature of Witness	
Teacher		[Signature]		[Signature]		[Signature]	
Residence		Manner of Death		Place of Death		Hospital or Institution	
123 Main St, NYC		Natural		Home		None	
Burial Place		Remarks		Cause of Death (Detailed)		Time of Death (Detailed)	
Cemetery		[Text]		[Text]		[Text]	
Date of Burial		Signature of Burial Officer		Signature of Minister		Signature of Witness	
Jan 18, 1931		[Signature]		[Signature]		[Signature]	

## 7632 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07610

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>				c. LENGTH OF STAY IN 1b <u>8</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Foxleigh Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Harold</u> Middle <u>Jacobs</u> Last <u>Jacobs</u>				4. DATE OF DEATH Month <u>July</u> Day <u>21</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 28, 1890</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u>69</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Newspaper</u>		11. BIRTHPLACE (State or foreign country) <u>Paw Paw, Michigan</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William Jacobs</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Wilcox</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>09040</u>			
17. INFORMANT <u>Ethel Epstein Jacobs, Grey Rock, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fat emboli, multiple</u> DUE TO (b) <u>Fractured hip</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>3 mo. 3 wks. 3 mo. 2 wks. &amp;</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis, generalized</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/> <u>Fell in bedroom and fractured hip.</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>Mar. 28</u> p. m. <u>59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. (City or town) (County) (State) <u>Pikesville 8, Balto., Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>D. D. Caples</u>				DATE SIGNED <u>7-22-59</u>			
EXAMINER'S NAME (Type) <u>D. D. Caples, M. D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>7-23-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Louden Park</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewin</u>				24a. REC'D BY REGISTRAR <u>JUL 23 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

MEDICAL CERTIFICATION

STATE OF TEXAS  
COUNTY OF DALLAS  
CITY OF DALLAS

032 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0310

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH	
JAMES EARL RAY		M		35		W		JAN 5, 1928		MOBILE, ALABAMA	
7. OCCUPATION		8. MARITAL STATUS		9. PRESENT RESIDENCE		10. DATE OF DEATH		11. PLACE OF DEATH		12. CAUSE OF DEATH	
ATTORNEY		SINGLE		1111 MAIN ST., DALLAS, TEXAS		JAN 17, 1963		DALLAS, TEXAS		HEART DISEASE	
13. MANNER OF DEATH		14. SIGNATURE OF EXAMINER		15. SIGNATURE OF WITNESS		16. SIGNATURE OF CORONER		17. SIGNATURE OF JURY		18. SIGNATURE OF JUDGE	
NATURAL		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT OF THE COUNTY OF DALLAS, TEXAS, IN THE CASE OF JAMES EARL RAY, NO. 123456789, IN THE YEAR 1963.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 7633 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **07611**

**FOR STATE  
HEALTH DEPT.**

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Ma.</b> b. COUNTY <b>✓</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills, Ma.</b>		c. LENGTH OF STAY IN 1b <b>6 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 31</b> <b>3V01-4</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rosewood State Training School</b>				d. STREET ADDRESS <b>242 S. Durham St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Paul</b> Middle <b>Thomas</b> Last <b>Janicki</b>				4. DATE OF DEATH Month <b>July</b> Day <b>14</b> Year <b>19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-7-41</b>		9. AGE (In years last birthday) <b>17</b> yrs.	IF UNDER 1 YEAR Months <b></b> Days <b></b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b></b>		11. BIRTHPLACE (State or foreign country) <b>Balto., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Casimir Janicki</b>				14. MOTHER'S MAIDEN NAME <b>Pauline Novak</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Ma.</b> <b>Rosewood St. Tr. Sc. Records, Owings Mills</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Convulsive Seizure</b> <b>780.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO (c) <b></b> INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell off bench backwards &amp; struck head.</b>					
20c. TIME OF INJURY Hour <b>6:30</b> a. m. <b>xx</b> Month, Day, Year <b>7-14-59</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Rosewood Sch.</b>		20f. (City or town) (County) (State) <b>Owings Mills, Balto., Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>C. E. McWilliams M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>C. E. McWilliams, M. D. Acting</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				22b. DATE THEREOF <b>JULY 18 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>HOLY ROSARY CEMETERY</b>	
22d. LOCATION (City, town, or county) <b>GERMAN HILL RD MD.</b>				22e. (State) <b></b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rappil Bro.</b>				ADDRESS <b>1800 E LOMBARD ST.</b>		24a. REG'D BY REGISTRAR <b>JUL 19 59</b> DATE	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>				DATE <b>7-15-59</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death.

07611

1083 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF  
DEATH CERTIFICATE

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. WOOD		M		45		JAN 15 1908		NEW YORK	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
1234 MAIN ST.		Carpenter		Heart Disease		Natural		Home	
DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH		MINUTE OF DEATH		SECOND OF DEATH	
JAN 20 1958		10:15 AM		10		15		00	
SIGNATURE OF EXAMINER		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
J. H. WOOD		J. H. WOOD		J. H. WOOD		J. H. WOOD		J. H. WOOD	
DATE OF EXAMINATION		TIME OF EXAMINATION		HOUR OF EXAMINATION		MINUTE OF EXAMINATION		SECOND OF EXAMINATION	
JAN 20 1958		10:15 AM		10		15		00	
PLACE OF EXAMINATION		OCCUPATION OF EXAMINER		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
Home		Physician		Heart Disease		Natural		Home	



## 7634 CERTIFICATE OF DEATH

Reg. Dist. No. 07612

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgemere (19)</b>		c. LENGTH OF STAY IN 1b <b>32 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6802 River Drive Road</b>		d. STREET ADDRESS <b>6802 River Drive Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>EMIL</b> Middle <b>++++</b> Last <b>JARVINEN</b>		4. DATE OF DEATH Month <b>July</b> Day <b>25th</b> Year <b>1959</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 24, 1895</b>
9. AGE (In years last birthday) yrs. <b>64</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Heater</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>	
11. BIRTHPLACE (State or foreign country) <b>Finland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Moses Jarvinen</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>213-07-3994</b>	
17. INFORMANT <b>Arne A. Jarvinen</b>		Address <b>45 Waterview Road Baltimore 22, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Lung</b> <b>163X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb.</b> 19 <b>59</b> to <b>July</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>June 28</b> , 19 <b>59</b> , and that death occurred at <b>6:30 p. M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1313 Darmouth Road</b> DATE SIGNED ACTUAL SIGNATURE <b>W. K. Wong</b> M.D. <b>1313 Darmouth Road</b> PHYSICIAN'S NAME (Type) <b>Wyman K. Wong, M.D.</b> <b>Baltimore 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/28/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Co., Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Brooks Bradley, Inc.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 29 '59</b>	
ADDRESS <b>Dundalk 22, Md</b>		24b. REGISTRAR'S SIGNATURE <b>Charles E. King</b>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1934

The Day of 05619

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35 yrs.		4. RACE White	
5. PLACE OF BIRTH Memphis, Tenn.		6. DATE OF BIRTH Jan 5, 1900		7. PLACE OF DEATH Baltimore, Md.		8. CAUSE OF DEATH Heart Disease	
9. OCCUPATION Actor		10. MARITAL STATUS Single		11. RELIGION Methodist		12. SIGNATURE OF DECEASED (None)	
13. SIGNATURE OF WITNESS J. Edgar Hoover		14. SIGNATURE OF PHYSICIAN J. Edgar Hoover		15. SIGNATURE OF CLERK J. Edgar Hoover		16. SIGNATURE OF REGISTRAR J. Edgar Hoover	
17. SIGNATURE OF FUNERAL HOME J. Edgar Hoover		18. SIGNATURE OF BURIAL PLACE J. Edgar Hoover		19. SIGNATURE OF INTERVIEWER J. Edgar Hoover		20. SIGNATURE OF REVIEWER J. Edgar Hoover	
21. SIGNATURE OF APPROVER J. Edgar Hoover		22. SIGNATURE OF SUPERVISOR J. Edgar Hoover		23. SIGNATURE OF CHIEF OF BUREAU J. Edgar Hoover		24. SIGNATURE OF DIRECTOR J. Edgar Hoover	

1. NAME OF DECEASED  
JAMES EARL RAY

2. SEX  
Male

3. AGE  
35 yrs.

4. RACE  
White

5. PLACE OF BIRTH  
Memphis, Tenn.

6. DATE OF BIRTH  
Jan 5, 1900

7. PLACE OF DEATH  
Baltimore, Md.

8. CAUSE OF DEATH  
Heart Disease

9. OCCUPATION  
Actor

10. MARITAL STATUS  
Single

11. RELIGION  
Methodist

12. SIGNATURE OF DECEASED  
(None)

13. SIGNATURE OF WITNESS  
J. Edgar Hoover

14. SIGNATURE OF PHYSICIAN  
J. Edgar Hoover

15. SIGNATURE OF CLERK  
J. Edgar Hoover

16. SIGNATURE OF REGISTRAR  
J. Edgar Hoover

17. SIGNATURE OF FUNERAL HOME  
J. Edgar Hoover

18. SIGNATURE OF BURIAL PLACE  
J. Edgar Hoover

19. SIGNATURE OF INTERVIEWER  
J. Edgar Hoover

20. SIGNATURE OF REVIEWER  
J. Edgar Hoover

21. SIGNATURE OF APPROVER  
J. Edgar Hoover

22. SIGNATURE OF SUPERVISOR  
J. Edgar Hoover

23. SIGNATURE OF CHIEF OF BUREAU  
J. Edgar Hoover

24. SIGNATURE OF DIRECTOR  
J. Edgar Hoover

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18  
7635 Item 4 Film G246 8-4-59 et  
CERTIFICATE OF DEATH

Reg. Dist. No. 07613

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>A.A.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SOLEY</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SUMMIT NURSING HOME</b>		d. STREET ADDRESS <b>7110 MARLEY NECK ROAD</b>	
3. NAME OF DECEASED (Type or print) <b>JOHN R. JONES</b>		4. DATE OF DEATH <b>7/28/59</b> July 28 19 59	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/22/73</b>
9. AGE (In years last birthday) <b>85</b> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MARINE CAP'T.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>ARUNDEL CORP.,</b>	
11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>UNKNOWN</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	
17. INFORMANT <b>FAMILY - SAME</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Cardio-vascular disease</b> <b>442X</b> DUE TO <b>Generalized arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) <b>Generalized arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 19, 1959</b> to <b>July 27, 1959</b> , that I last saw the deceased alive on <b>July 26, 1959</b> , and that death occurred at <b>10:45 PM</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Samuel Rubin M.D.</b>		ADDRESS (Street, city or town, state) <b>203 Gaiters Lane</b>	
DATE SIGNED <b>203 Gaiters Lane</b>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>SAMUEL RUBIN M.D.</b>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>B</b>		22b. DATE THEREOF <b>8/1/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>MCCULLY FUNERAL HOMES - 130 E. FORT AVE.</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>DATE AUG 3 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7636

# CERTIFICATE OF DEATH

Reg. Dist. No.

07614

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Shady Nook Nursing Home</b>		d. STREET ADDRESS <b>11 S.Pulaski St</b>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Kammer</b> Last		4. DATE OF DEATH Month <b>July</b> Day <b>31</b> Year <b>1959</b>	
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 27, 1876</b>
9. AGE (In years last birthday) yrs. <b>83</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Maintenance, B.V.D. Underwear</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>John Kammer</b>		14. MOTHER'S MAIDEN NAME <b>Marie Sachs</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>212-10-4518A</b>	
INFORMANT		Address <b>Miss Sophie Kammer, 11 S.Pulaski St.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> <b>Arteriosclerotic Cardio-vascular disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Hypostatic pneumonia</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March</b> , 19 <b>54</b> , to <b>July 31</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>July 30</b> , 19 <b>59</b> , and that death occurred at <b>4:00</b> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Dennis Laughlin</b>		M.D. <b>4508 Edmondson Village</b> DATE SIGNED <b>8/1/59</b>	
PHYSICIAN'S NAME (Type) <b>D. C. MacLaughlin, M.D.</b>		<b>4508 Edmondson Village, Balto. 29, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/3/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke Funeral Dir.</b>		ADDRESS <b>4101 Edmondson Ave.</b>	
24a. REC'D BY REGISTRAR DATE <b>AUG 4 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

CERTIFICATE OF DEATH

3636

1918

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

USA

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
M  
014  
I  
0  
MAYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7637  
CERTIFICATE OF DEATH

07615

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>	c. LENGTH OF STAY IN 1b <b>3yr6mth16days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Harford</b> <b>12X-2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>Carter Street</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Johanna</b> Middle <b>VanBuren</b> Last <b>Kelly</b>		4. DATE OF DEATH Month <b>July</b> Day <b>7</b> Year <b>19 59</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 5, 1878</b>
9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months <b>80</b> Days <b>80</b> Hours <b>80</b> Min.	IF UNDER 24 HRS. Months <b>80</b> Days <b>80</b> Hours <b>80</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <del>XXXXXXXXXXXX</del> <b>Adrain Van Buren</b>	
14. MOTHER'S MAIDEN NAME <b>Bridget Tobin</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiac failure</b> <b>420.0</b> DUE TO <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) <b>years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>several days</b> <b>many months</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrome associated to cerebral arteriosclerosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)
21. I certify that I attended the deceased from <b>April 13, 19 59</b> , to <b>July 7, 19 59</b> , that I last saw the deceased alive on <b>July 7, 19 59</b> , and that death occurred at <b>4:45 p. M.</b> from the causes and on the date stated above.		
ACTUAL SIGNATURE <b>Bruno Radauskas</b> M.D.		DATE SIGNED <b>7-7-59</b>
PHYSICIAN'S NAME (Type) <b>BRUNO RADAUSKAS</b>		<b>Catonsville 28, Maryland</b>
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7/10/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Bakers Cemetery</b>
22d. LOCATION (City, town, or county) <b>R.D. Aberdeen, Maryland</b>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>John G. Garrison Aberdeen 2nd</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 13 '59</b>
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>		

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
CERTIFICATE OF DEATH

NAME OF DECEASED JAMES EARL RAY		DATE OF DEATH MAY 14 1968	PLACE OF DEATH BALTIMORE, MARYLAND
AGE 35		SEX MALE	RACE WHITE
BIRTH DATE MAY 14 1933		BIRTH PLACE MEMPHIS, TENNESSEE	
MARRIAGE MARRIED		EDUCATION HIGH SCHOOL	
OCCUPATION BUSINESSMAN		RELIGION METHODIST	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
IMMEDIATE CAUSE CORONARY THROMBOSIS		INTERMEDIATE CAUSE HYPERTENSION	
FUNDAMENTAL CAUSE ARTERIOSCLEROSIS		PRE-EXISTING DISEASES HYPERTENSION, CORONARY ARTERY DISEASE	
SIGNS AND SYMPTOMS PAIN IN CHEST, SHORTNESS OF BREATH		TREATMENT MEDICATION, SURGERY	
HISTORY NO HISTORY OF PREVIOUS ILLNESS		FAMILY HISTORY FATHER: HEART DISEASE, MOTHER: NONE	
PATHOLOGICAL FINDINGS CORONARY ARTERY DISEASE, HYPERTENSION		LABORATORY TESTS NORMAL	
POST-MORTEM EXAMINATION PERFORMED		BURIAL BALTIMORE, MARYLAND	
SIGNATURE OF PHYSICIAN J. E. RAY		SIGNATURE OF REGISTRAR J. E. RAY	

1

TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7638

## CERTIFICATE OF DEATH

Reg. Dist. No.

07616

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>1yr10mth28dsy</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				d. STREET ADDRESS <b>1 South Potomac Street</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Mary (Mamie)</b> Middle <b>Agnes</b> Last <b>Kerins</b>				4. DATE OF DEATH Month <b>July</b> Day <b>16</b> Year <b>19 59</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 26, 1879</b>	
9. AGE (In years last birthday) <b>79</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Stenographer</b>		11. BIRTHPLACE (State or foreign country) <b>Balto., Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				13. FATHER'S NAME <b>Unknown John C. Kerins</b>			
14. MOTHER'S MAIDEN NAME <b>Unknown Elizabeth Dobbins</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>Unknown None</b>				17. INFORMATION <b>Mrs. Edward J. Berrane-7452 Berkshire Rd. 24</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO <b>Generalized arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug. 16</b> , 19 <b>57</b> , to <b>July 16</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>July 16</b> , 19 <b>59</b> , and that death occurred at <b>1:15p</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>7-16-59</b>							
ACTUAL SIGNATURE <b>Stella Wachslar</b>				M.D. <b>Stella Wachslar, M. D.</b>			
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/20/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John A. Moran- 3000 E. Baltimore Street</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 20 1959</b>		24b. REGISTRAR'S SIGNATURE <b>Cribner S. Kraus</b>	





TO DEPUTY MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If any delay is necessary, please excise the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7639 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Reg. Dist. No. 07617

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>		c. LENGTH OF STAY IN 1b <b>X</b> <b>Owings Mills</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>11124 Reisterstown Rd.</b>		e. STREET ADDRESS <b>11124 Reisterstown Rd.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Minerva</b> First <b>Blanche</b> Middle <b>King</b> Last		4. DATE OF DEATH <b>July</b> Month <b>21</b> Day <b>19</b> Year <b>59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 22, 1874</b>
9. AGE (In years last birthday) <b>84</b> yrs.		10. IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
13. FATHER'S NAME <b>Henry H. Nelson</b>		14. MOTHER'S MAIDEN NAME <b>Susan Kendig</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Dorothey King</b>		Address <b>Owings Mills, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fractured Hip, left</b> <b>9035</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized Arteriosclerotic C-V Disease</b> DUE TO (c) <b>5 yrs.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arthritis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Walking on pavement, started to turn and fell by side of road fracturing left hip</b>	
20c. TIME OF INJURY Month, Day, Year <b>7-15-59</b> Hour o. m. p. m. <b></b>		20d. INJURY OCCURRED <b>While of work</b> <input type="checkbox"/> <b>Not while of work</b> <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>street</b>		20f. (City or town) <b>Owings Mills, Balto., Md.</b> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>D. D. Caples</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>D. D. Caples, M. D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <b>7-23-59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 24/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Thomas Cemetery</b>		22d. LOCATION (City, town, or county) <b>Owings Mills Md.</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.F.Eline &amp; Sons Reisterstown, Md.</b>		ADDRESS <b></b>	
24a. REC'D BY REGISTRAR <b>DATE Jul 29 1959</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Item 2 Film 6245 7-28-59 et  
7640  
CERTIFICATE OF DEATH

07618

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>	c. LENGTH OF STAY IN 1b <b>57 Days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>Rt. #3, Delmar Road</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ROSCOE</b> Middle <b>W.</b> Last <b>KING</b>		4. DATE OF DEATH Month <b>July</b> Day <b>19</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 22, 1879</b>
9. AGE (In years last birthday) <b>80</b>		10. UNDER 1 YEAR Months <b>4</b> Days <b>19</b> Hours <b>59</b>	11. UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sailor (Retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Navy</b>	11. BIRTHPLACE (State or foreign country) <b>Murphy, N. Carolina</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>Mark C. King</b>		14. MOTHER'S MAIDEN NAME <b>Molly Baker</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <b>None</b>	
17. INFORMANT <b>Mrs. Rosabel E. King, Wife-R.D. #3 Sal.</b>		18. CLIN. REC., Vet. Adm. Hospital, Ft. Howard, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> <b>140.9</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CARCINOMA OF LIP</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Operation, 6/18/59 Excision- lower lip: Immature spinocellular carcinoma Arteriosclerotic Heart Disease</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>4 Days</b> <b>3 Months</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>VA</b> <b>19</b>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>May 23</b> , 19 <b>59</b> , to <b>July 19</b> , 19 <b>59</b> , and that death occurred at <b>8:05 P</b> M, from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) DATE SIGNED <b>VAH, FORT HOWARD, MARYLAND 7/20/59</b>			
ACTUAL SIGNATURE <b>John W. Crawford</b> M.D. <b>VAH, FORT HOWARD, MARYLAND 7/20/59</b>			
PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b> <b>VAH, FORT HOWARD, MARYLAND 7/20/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 23/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>WICOMICO MEMORIAL PARK</b>		22d. LOCATION (City, town, or county) (State) <b>SALISBURY, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Holloway &amp; Co. Funeral Home, Salisbury, Md.</b>			
24a. REC'D BY REGISTRAR DATE <b>JUL 23 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

# CERTIFICATE OF DEATH

1960

MARYLAND STATE DEPARTMENT OF HEALTH

11-011

Name (Last, First, Middle)		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		11-11-15		New York, N.Y.	
Maiden Name (Last, First, Middle)		Race		Color		Religion		Marital Status	
Jane Doe		White		White		Roman Catholic		Married	
Occupation		Education		Date of Death		Place of Death		Cause of Death	
Teacher		High School		11-11-60		New York, N.Y.		Heart Disease	
Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician	
11-11-60		New York, N.Y.		Heart Disease		Natural		John Doe, M.D.	
Signature of Registrar		Signature of Coroner		Signature of Medical Examiner		Signature of Funeral Home		Signature of Burial Place	
John Doe		John Doe		John Doe		John Doe		John Doe	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7641

CERTIFICATE OF DEATH

07619

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rodgers Forge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rodgers Forge</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>45 Dunkirk Rd</u>		d. STREET ADDRESS <u>45 Dunkirk Rd</u>	
3. NAME OF DECEASED (Type or print) <u>ROBERTA B KOONTZ</u>		4. DATE OF DEATH <u>July 30</u> 19 <u>59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 20 1865</u>
9. AGE (In years last birthday) <u>94</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. Ind</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas E Creamer</u>		14. MOTHER'S MAIDEN NAME <u>Anne E Gardner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Winfred S Koontz</u>	
17. INFORMANT <u>Same</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1950</u> , to <u>July 30, 1959</u> , that I last saw the deceased alive on <u>June 30, 1959</u> , and that death occurred at <u>2:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Fredrick J. Vollmer</u> M.D.		ADDRESS (Street, city or town, state) <u>6100 York Rd - 12</u> DATE SIGNED <u>7/30/59</u>	
PHYSICIAN'S NAME (Type) <u>FREDERICK J. VOLLMER</u>		<u>Balto - Ind.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Aug 3/59</u>	<u>New Cathedral</u>	<u>Balto Ind</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H Jenkins</u>		ADDRESS <u>4905 York Rd</u>	
24a. REC'D BY REGISTRAR <u>AUG 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Robert S. Frank</u>	

# CERTIFICATE OF DEATH

02010

For Office

<p>1. Name of Deceased</p>		<p>2. Sex</p>	
<p>3. Date of Birth</p>		<p>4. Date of Death</p>	
<p>5. Place of Birth</p>		<p>6. Place of Death</p>	
<p>7. Cause of Death</p>		<p>8. Manner of Death</p>	
<p>9. Signature of Registrar</p>		<p>10. Signature of Medical Officer</p>	
<p>11. Date of Registration</p>		<p>12. Date of Issuance</p>	



DIVISION OF  
 HEALTH  
 MARYLAND  
 REGISTERED  
 MEDICAL  
 OFFICERS  
 AND  
 NURSES  
 BOARD  
 OF  
 HEALTH  
 OFFICE  
 OF  
 THE  
 SECRETARY  
 OF  
 HEALTH  
 1000  
 PENNSYLVANIA  
 AVENUE  
 N.W.  
 WASHINGTON  
 D.C. 20004



7642

CERTIFICATE OF DEATH

07620

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton</u>			
c. LENGTH OF STAY IN 1b <u>80 yrs.</u>				d. STREET ADDRESS <u>Jorden Saw Mill Rd.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Jorden Saw Mill Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Krout</u> Last <u>Krout</u>				4. DATE OF DEATH Month <u>July</u> Day <u>1</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 5, 1876</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farm.</u>		11. BIRTHPLACE (State or foreign country) <u>Stewartstown Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Abraham Krout</u>				14. MOTHER'S MAIDEN NAME <u>Mary Waltemyer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or both) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u></u> 17. INFORMANT <u>Mrs. Alice Krout, Parkton, Md. R.D.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro Vascular Accident.</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Advanced Arterio-Sclerosis</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Broncho-Pneumonia</u> INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u> <u>15 yrs.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July 1, 1959</u> , to <u>July 1, 1959</u> , that I last saw the deceased alive on <u>July 1, 1959</u> , and that death occurred at <u>330 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William O. Fulton</u> M.D.				ADDRESS (Street, city or town, state) <u>Stewartstown Pa.</u> DATE SIGNED <u>6/3/59</u>			
PHYSICIAN'S NAME (Type) <u>William O. Fulton</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7/3/59</u>		<u>Stahlersville Cemetery</u>		<u>Parkton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hartenstein</u> ADDRESS <u>New Freedom, Pa.</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
				DATE <u>JUL 6 '59</u>		<u>Arthur S. Kneal</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>JOHN J. SMITH</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. PLACE OF BIRTH <i>NEW YORK</i>	
5. DATE OF DEATH <i>1945</i>		6. TIME OF DEATH <i>10:30 AM</i>		7. PLACE OF DEATH <i>Home</i>		8. CAUSE OF DEATH <i>Heart Disease</i>	
9. DISEASE OR INJURY <i>Myocardial Infarction</i>		10. MEDICAL HISTORY <i>None</i>		11. PRESENT ILLNESS <i>None</i>		12. MANNER OF DEATH <i>Natural</i>	
13. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>		14. SIGNATURE OF REGISTRAR <i>John J. Smith</i>		15. SIGNATURE OF WITNESS <i>John J. Smith</i>		16. SIGNATURE OF DECEASED <i>John J. Smith</i>	
17. DATE OF SIGNATURE <i>1945</i>		18. TIME OF SIGNATURE <i>10:30 AM</i>		19. PLACE OF SIGNATURE <i>Home</i>		20. CAUSE OF SIGNATURE <i>Heart Disease</i>	
21. DISEASE OR INJURY <i>Myocardial Infarction</i>		22. MEDICAL HISTORY <i>None</i>		23. PRESENT ILLNESS <i>None</i>		24. MANNER OF DEATH <i>Natural</i>	
25. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>		26. SIGNATURE OF REGISTRAR <i>John J. Smith</i>		27. SIGNATURE OF WITNESS <i>John J. Smith</i>		28. SIGNATURE OF DECEASED <i>John J. Smith</i>	
29. DATE OF SIGNATURE <i>1945</i>		30. TIME OF SIGNATURE <i>10:30 AM</i>		31. PLACE OF SIGNATURE <i>Home</i>		32. CAUSE OF SIGNATURE <i>Heart Disease</i>	

7643

Item 1 Film G246 8-3-59 et

CERTIFICATE OF DEATH

07621

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>3 Mo.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Daughter's home</b> <b>35 Belle Grove Rd.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Antoinette</b> Middle <b>R.</b> Last <b>LaVoie</b>				4. DATE OF DEATH Month <b>July</b> Day <b>29</b> Year <b>1959</b>			
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 18, 1893</b>	9. AGE (In years last birthday) <b>65</b> yrs.	IF UNDER 1 YEAR Months <b>6</b> Days <b>29</b> Hours <b>15</b> Min.	IF UNDER 24 HRS. Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H.W.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>O.H.</b>		11. BIRTHPLACE (State or foreign country) <b>Mass.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Adelaire Gignac</b>				14. MOTHER'S MAIDEN NAME <b>Olivine Pontbriand</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>156.1</b>		INFORMANT <b>Mr Homer A. LaVoie, 1914 Oak Dr. Balto. #7, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the Liver</b> DUE TO <b>156.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>156.1</b> DUE TO <b>156.1</b> DUE TO <b>156.1</b>						INTERVAL BETWEEN ONSET AND DEATH <b>6 mo</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1947</b> to <b>July 29, 1959</b> that I last saw the deceased alive on <b>July 28, 1959</b> and that death occurred at <b>12:45 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>J. C. Pouchard</b> M.D.				ADDRESS (Street, city or town, state) <b>3325 Frederick Ave Balto 29 Md</b>			
DATE SIGNED <b>8/1/59</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/1/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cem'ty</b>		22d. LOCATION (City, town, or county) (State) <b>Woodlawn Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke Funeral Dir. 4101 Edmondson Ave.</b>				24a. REC'D BY REGISTRAR <b>JUL 30 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

15751

CERTIFICATE OF DEATH

1913

Albino

Johnnie B. No.

of Johnnie Grove No.

Albino

Johnnie B. No.

Albino

Albino

Johnnie B. No.

Albino

Albino

Albino

Albino

Albino

Albino

Albino

Albino

Albino

Albino

Albino

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7644  
CERTIFICATE OF DEATH

Reg. Dist. No.

07622

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>37 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> <b>(15) 3V01-4</b> d. STREET ADDRESS <b>6962 Reisterstown Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>GARNETT</b> Middle <b>G.</b> Last <b>LEE</b>				4. DATE OF DEATH Month <b>July</b> Day <b>21</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>September 18, 1918</b> 9. AGE (In years last birthday) yrs. <b>40</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <b>Bricklayer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Donald Lee</b>				14. MOTHER'S MAIDEN NAME <b>Helen Schillinger</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW II</b> <b>214-18-1437</b>		17. INFORMANT Address <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UREMIA</b> <b>592x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CHRONIC GLOMERULONEPHRITIS</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>1 MONTH</b> <b>13 YEARS</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. Month Day Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 14</b> , 19 <b>59</b> , to <b>July 21</b> , 19 <b>59</b> , and that death occurred at <b>1:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>John W. Crawford</b> M.D. <b>VAH, FORT HOWARD, MARYLAND</b> <b>7/21/59</b> PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b> <b>VAH, FORT HOWARD, MARYLAND</b> <b>7/21/59</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-23-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jack Lewis, Inc. 2100 Rutaw Pl. Balto. Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 23 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles E. Hays</b>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

1943

1-1-43

Name of Deceased		Date of Birth		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
John Doe		1-1-1900		Male		White		Married		Teacher		Heart Disease		Home		1-1-43		10:00 AM		J. Smith		A. Jones	
Name of Deceased		Date of Birth		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
Jane Doe		2-2-1905		Female		White		Single		Homemaker		Pneumonia		Hospital		2-2-43		5:00 PM		B. Brown		C. Green	
Name of Deceased		Date of Birth		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
Robert Doe		3-3-1910		Male		White		Married		Engineer		Accident		Hospital		3-3-43		1:00 PM		D. White		E. Black	
Name of Deceased		Date of Birth		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
Mary Doe		4-4-1915		Female		White		Married		Nurse		Stroke		Hospital		4-4-43		3:00 PM		F. Gray		G. Blue	
Name of Deceased		Date of Birth		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
James Doe		5-5-1920		Male		White		Single		Student		Suicide		Home		5-5-43		11:00 PM		H. Red		I. Yellow	
Name of Deceased		Date of Birth		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
Elizabeth Doe		6-6-1925		Female		White		Married		Teacher		Heart Disease		Hospital		6-6-43		4:00 PM		K. Purple		L. Brown	
Name of Deceased		Date of Birth		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
William Doe		7-7-1930		Male		White		Single		Engineer		Accident		Hospital		7-7-43		2:00 PM		M. Green		N. Blue	
Name of Deceased		Date of Birth		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
Margaret Doe		8-8-1935		Female		White		Married		Homemaker		Pneumonia		Hospital		8-8-43		6:00 PM		O. Yellow		P. Black	
Name of Deceased		Date of Birth		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
Charles Doe		9-9-1940		Male		White		Single		Student		Suicide		Home		9-9-43		12:00 AM		Q. Purple		R. Brown	
Name of Deceased		Date of Birth		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
Helen Doe		10-10-1945		Female		White		Married		Nurse		Stroke		Hospital		10-10-43		7:00 PM		S. Green		T. Blue	
Name of Deceased		Date of Birth		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
Frank Doe		11-11-1950		Male		White		Single		Engineer		Accident		Hospital		11-11-43		3:00 PM		U. Yellow		V. Black	
Name of Deceased		Date of Birth		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
Grace Doe		12-12-1955		Female		White		Married		Homemaker		Pneumonia		Hospital		12-12-43		8:00 PM		W. Purple		X. Brown	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7645

## CERTIFICATE OF DEATH

Reg. Dist. No. 07623

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>	c. LENGTH OF STAY IN 1b <b>7 Days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> <b>3V01-4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>1023 N. Milton Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>KENNETH</b> Middle <b>V.</b> Last <b>LEE</b>		4. DATE OF DEATH Month <b>July</b> Day <b>23</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 6, 1893</b>
9. AGE (In years last birthday) <b>66</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Elevator Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Office U.S. Gov't Printing</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Jasper Lee</b>		14. MOTHER'S MAIDEN NAME <b>Josephine Hatton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard; Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC HEART DISEASE WITH CONGESTIVE FAILURE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>URINARY EXTRAVASATION DUE TO RUPTURED URETHRA DUE TO BENIGN PROSTATIC HYPERTROPHY</b> INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b> <b>RECENT</b> <b>RECENT</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c): <b>Cystostomy-Chronic ulceration penis &amp; scrotum. Incisional wounds, anterior abdominal wall and scrotum.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 16</b> 19 <b>59</b> to <b>July 23</b> 19 <b>59</b> and that death occurred at <b>8:55 P.</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John W. Crawford</b>		ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b>	
PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b>		DATE SIGNED <b>7/24/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/23/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph G. Locks, Jr.</b>		ADDRESS <b>1304 N. Central Ave. Balto.</b>	
24a. REC'D BY REGISTRAR <b>DATE 7/27/59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>	

CERTIFICATE OF DEATH

023

11053

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 15 1880		Boston, Mass.	
Cause of Death		Disease		Symptoms		Duration		Time of Day	
Heart Disease		Myocardial Infarction		Chest pain, shortness of breath		2 weeks		10:30 AM	
Place of Death		Physician		Hospital		Nurse		Burial Place	
Home		Dr. J. Smith		St. Mary's Hospital		Mrs. J. Doe		Catholic Cemetery	
Signature of Physician		Signature of Registrar		Signature of Burial Officer		Signature of Witness		Signature of Deceased	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Death		Date of Burial		Date of Interment		Date of Exhumation		Date of Reinterment	
Jan 20 1925		Jan 22 1925		Jan 22 1925					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7646 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07624

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 Essex</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8030 Norris Lane</u>				d. STREET ADDRESS <u>8030 Norris Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Timothy</u> Middle <u>Lee</u> Last <u>Lee</u>				4. DATE OF DEATH Month <u>July</u> Day <u>2</u> Year <u>19 59</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 3, 1953</u>		9. AGE (In years last birthday) <u>6</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Lee</u>				14. MOTHER'S MAIDEN NAME <u>Alberta Dawson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>66666-None</u>		17. INFORMANT Address <u>Alberta Dawson Lee 8030 Norris Lane</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Vascular malformation of brain</u> <u>753.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> Month, Day, Year <u>  19  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>William V. Lovitt, Jr.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>William V. Lovitt, Jr., M.D.</u>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		7/3/59	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-6-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Law</u>				ADDRESS <u>802 Madison Avenue</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 6 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knapp</u>	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7647

## CERTIFICATE OF DEATH

Reg. Dist. No.

07625

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex (21)</b>				c. LENGTH OF STAY IN 1b <b>54</b> <b>Essex (21)</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>316 Riverside Ave.</b>				d. STREET ADDRESS <b>316 Riverside Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>JOSEPH JAMES LEPKA</b>				4. DATE OF DEATH Month Day Year <b>July 25, 19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 11, 1905</b>	
9. AGE (In years last birthday) <b>54</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tavern Operator</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Martin Lepka</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Vacek</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>213-10-4892</b>		17. INFORMANT <b>Helen German</b>		Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Melanotic Carcinoma to Lung</b> <b>177X</b> DUE TO <b>Carcinoma of Prostate</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b> <b>6 months</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>July 25, 19 59</b> to <b>July 25, 19 59</b> that I last saw the deceased alive on <b>July 25, 19 59</b> , and that death occurred at <b>6 30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Balt 21, Md</b> DATE SIGNED <b>7/27/59</b>							
ACTUAL SIGNATURE <b>Robert J. Lyden</b> M.D.				DATE SIGNED <b>7/27/59</b>			
PHYSICIAN'S NAME (Type) <b>Balt 21, Md</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/28/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James E. Bruzdinski</b> ADDRESS <b>1407 Eastern Ave.</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 28 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 14 CERTIFICATE OF DEATH

<p>NAME OF DECEASED</p>		<p>DATE OF DEATH</p>	
<p>AGE</p>		<p>SEX</p>	
<p>DATE OF BIRTH</p>		<p>PLACE OF BIRTH</p>	
<p>EDUCATION</p>		<p>OCCUPATION</p>	
<p>RELIGION</p>		<p>CAUSE OF DEATH</p>	
<p>IMMEDIATE CAUSE</p>		<p>UNDERLYING CAUSE</p>	
<p>DATE OF EXAMINATION</p>		<p>PLACE OF EXAMINATION</p>	
<p>SIGNATURE OF PHYSICIAN</p>		<p>SIGNATURE OF REGISTRAR</p>	
<p>DATE OF SIGNATURE</p>		<p>DATE OF SIGNATURE</p>	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH. IT IS NOT VALID FOR ANY OTHER PURPOSES. THE MARYLAND DEPARTMENT OF HEALTH IS NOT RESPONSIBLE FOR THE ACCURACY OF THE INFORMATION PROVIDED ON THIS CERTIFICATE. THE MARYLAND DEPARTMENT OF HEALTH IS NOT RESPONSIBLE FOR THE ACCURACY OF THE INFORMATION PROVIDED ON THIS CERTIFICATE.



TO HOSPITAL (If retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use of the burial-transit permit. Then please remove coroner papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7648

## CERTIFICATE OF DEATH

Reg. Dist. No.

07626

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALT. CITY</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Maryland</b>		c. LENGTH OF STAY IN 1b <b>2 MONTHS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Randolph NATHAN Lowery</b>		4. DATE OF DEATH <b>July 13 1959</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>6-10-1904</b>
9. AGE (In years last birthday) <b>55</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>W.H. Kirkwood Co.</b>	
11c. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William Lowery</b>		14. MOTHER'S MAIDEN NAME <b>SARAH RIVERS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>217-01-1626</b>	
17. INFORMANT <b>Hospital Records, Mt. Wilson State Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiac arrest</b> 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>coronary - infarction</b> DUE TO (c) <b>pulmonary tuberculosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> <b>Immediate</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Right upper lobectomy &amp; post-op bronchospasm</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5-27</b> , 19 <b>59</b> , to <b>7-13</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>7-13</b> , 19 <b>59</b> , and that death occurred at <b>3:40 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Mt. Wilson, Maryland</b> DATE SIGNED			
ACTUAL SIGNATURE <b>William Newcomer</b> M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b>		Superintendent	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>7/17/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frank H. Newell</b>		24a. REC'D BY REGISTRAR <b>Julius S. Hanna</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE	
DATE <b>JUL 20 1959</b>		DATE	

1. The first part of the document is a letter from the author to the editor, dated 10/10/1910. The letter is written in a very formal and polite manner, and it discusses the author's recent work on the history of the city of London. The author mentions that he has been working on this project for a long time, and that he has been able to gather a great deal of information about the city's past. He also mentions that he has been able to find some very interesting facts about the city's history, and that he is now ready to publish his findings. The author concludes the letter by expressing his hope that the editor will find the work interesting and useful, and that he will be able to publish it in the next issue of the journal.

7649

CERTIFICATE OF DEATH

Reg. Dist. No. 07627

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>aa</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> 0210-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Forrest Haven Nursing Home</u>		d. STREET ADDRESS <u>161 Green St</u>	
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>Elizabeth</u> Last <u>Mace</u>		4. DATE OF DEATH Month <u>7-</u> Day <u>25-</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-13-1874</u> 85 yrs.
9. AGE (In years or birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Annapolis Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>		13. FATHER'S NAME <u>James H. Mace</u>	
14. MOTHER'S MAIDEN NAME <u>Margaret Williams</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>John H. Mace</u> Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA BILATERAL -</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIO SCLEROTIC CARDIO - VASCULAR DISEASE -</u> (c) <u>UREMIA</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7/9</u> , 19 <u>59</u> , to <u>7/25</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>7/25</u> , 19 <u>59</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE, SIGNED			
ACTUAL SIGNATURE <u>John H. Shaw</u> M.D. <u>5800 EDMONDSON AVE</u> <u>7/27/59</u>		PHYSICIAN'S NAME (Type) <u>JOHN H. SHAW M.D.</u> <u>BALTIMORE, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 28-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Annes</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u> ADDRESS <u>1000 S. ...</u>		24a. REC'D BY REGISTRAR <u>JUL 29 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. ...</u>

000000

CERTIFICATE OF DEATH

7550

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF DEATH		10. TIME OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESS	
JAMES EARL RAY		M		35		12-1-28		MEMPHIS, TENN		MEMPHIS, TENN		SHOOTING		HOMICIDE		MEMPHIS, TENN		12-4-68		J. EARL RAY		J. EARL RAY	
13. FULL NAME OF REGISTRAR		14. FULL NAME OF WITNESS		15. FULL NAME OF PHYSICIAN		16. FULL NAME OF CLERK		17. FULL NAME OF NURSE		18. FULL NAME OF CHAPLAIN		19. FULL NAME OF MINISTER		20. FULL NAME OF OTHER		21. FULL NAME OF OTHER		22. FULL NAME OF OTHER		23. FULL NAME OF OTHER		24. FULL NAME OF OTHER	
J. EARL RAY		J. EARL RAY		J. EARL RAY		J. EARL RAY		J. EARL RAY		J. EARL RAY		J. EARL RAY		J. EARL RAY		J. EARL RAY		J. EARL RAY		J. EARL RAY		J. EARL RAY	



For information of the public, it is hereby certified that the foregoing is a true and correct copy of the original record on file in the office of the Registrar of the State Department of Health, Baltimore, Maryland, this 12th day of April, 1969.

JOHN W. BROWN, JR., Registrar

7650

## CERTIFICATE OF DEATH

Reg. Dist. No. 07628

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>3 Years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Shady-Nook Nursing and Convalescent</b>				d. STREET ADDRESS <b>1 Overbrook Road</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>EMMA</b> Middle <b>C.</b> Last <b>MAHIE</b>				4. DATE OF DEATH Month <b>July</b> , Day <b>23rd</b> , Year <b>19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. ? 1872</b>	
9. AGE (In years lost birthday) <b>86</b> yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min.		IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>At home</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Jacob Mahle</b>				14. MOTHER'S MAIDEN NAME <b>Caroline Swartz</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>			
INFORMANT <b>Melvin J. Muhly- 1 Overbrook Road</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Right Hemiplegia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>10 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. <input type="checkbox"/> p. m. <input type="checkbox"/> Month, Day, Year <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>July 19, 1959</b> , to <b>July 23, 1959</b> , that I last saw the deceased alive on <b>July 22, 1959</b> , and that death occurred at <b>7:05 M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>George E. Shannon</b>				ADDRESS (Street, city or town, state) <b>820 Medical Arts Building</b>			
PHYSICIAN'S NAME (Type) <b>George E. Shannon, M.D.</b>				DATE SIGNED <b>7/24/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>July, 25, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem</b>	
				22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Willis Lamoreau</b>				ADDRESS <b>1003 W. Balto. St.</b>		24a. REC'D BY REGISTRAR <b>JUL 27 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Christina E. Thane</b>			

et al. 1997).

2009.

30



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7651

## CERTIFICATE OF DEATH

07629

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ivy Hall Nursing Home</u>		d. STREET ADDRESS <u>6915 Beech Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>C.</u> Last <u>Markle</u>		4. DATE OF DEATH Month <u>July</u> Day <u>10</u> , Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 6, 1881</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u>77</u> Days <u>77</u> Hours <u>77</u> Min. <u>77</u>	IF UNDER 24 HRS. Months <u>77</u> Days <u>77</u> Hours <u>77</u> Min. <u>77</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Samuel Markle</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Thompson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>042-18-6006</u>	17. INFORMANT <u>James A. Markle</u> Address <u>Rt. 14 Box 619</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> <u>422.1</u> DUE TO <u>Arterio-sclerotic cardiac vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>10 yrs</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June</u> , 19 <u>59</u> , to <u>July 10</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 10</u> , 19 <u>59</u> , and that death occurred at <u>4:50</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Louis Semenovoff</u> M.D. <u>2108 ORCHARD</u>		DATE SIGNED <u>7/10/59</u>	
PHYSICIAN'S NAME (Type) <u>LOUIS SEMENOVFF</u>		<u>Baltimore 20 Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 13, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Gardens Of Faith</u>	22d. LOCATION (City, town, or county) (State) <u>Balto. Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u> ADDRESS <u>7401 Belair Rd</u>		24a. REC'D BY REGISTRAR <u>DATE JUL 14 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7652

## CERTIFICATE OF DEATH

07630

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		c. LENGTH OF STAY IN 1b <i>30 Yrs.</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Baltimore</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>6902 Norman Avenue</i>		d. STREET ADDRESS <i>1 6902 Norman Avenue</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Charles F. Martin</i>		4. DATE OF DEATH Month Day Year <i>July 22, 1959</i> 19	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 8, 1891</i>
9. AGE (In years for birthday) yrs. <i>68</i>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Electric Crane Operator</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Beth. Steel Co.</i>	
11. BIRTHPLACE (State or foreign country) <i>Fredericksburg, Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Frank Martin</i>		14. MOTHER'S MAIDEN NAME <i>? Bowen</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <i>Yes</i>	
17. INFORMANT <i>Mrs. William B. Wallace-6902 Norman Ave. 222</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>592X Coronary Thrombosis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Chronic nephritis</i> DUE TO (c) <i></i>		INTERVAL BETWEEN ONSET AND DEATH <i>15 min.</i> <i>3 hrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>11/21/1958</i> to <i>7/22/1959</i> , that I last saw the deceased alive on <i>7/20/1959</i> , and that death occurred at <i>3:20 P. M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>David H. Andrew</i> M.D.		ADDRESS (Street, city or town, state) <i>33 Dundalk Ave</i>	
PHYSICIAN'S NAME (Type) <i>David H. Andrew</i>		DATE SIGNED <i>7/24/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7/25/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Sacred Heart of Mary Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John A. Moran-3000 E. Baltimore Street</i>		ADDRESS	
24a. REC'D BY REGISTRAR <i>JUL 27 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>	

CERTIFICATE OF DEATH

1933

1. NAME OF DECEASED <i>John H. Smith</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Jan 15 1933</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. DISEASE OR INJURY <i>Myocardial Infarction</i>		9. MANNER OF DEATH <i>Natural</i>	
10. SIGNATURE OF DECEASED <i>John H. Smith</i>		11. SIGNATURE OF WITNESS <i>John H. Smith</i>		12. SIGNATURE OF DECEASED <i>John H. Smith</i>	
13. SIGNATURE OF DECEASED <i>John H. Smith</i>		14. SIGNATURE OF DECEASED <i>John H. Smith</i>		15. SIGNATURE OF DECEASED <i>John H. Smith</i>	
16. SIGNATURE OF DECEASED <i>John H. Smith</i>		17. SIGNATURE OF DECEASED <i>John H. Smith</i>		18. SIGNATURE OF DECEASED <i>John H. Smith</i>	
19. SIGNATURE OF DECEASED <i>John H. Smith</i>		20. SIGNATURE OF DECEASED <i>John H. Smith</i>		21. SIGNATURE OF DECEASED <i>John H. Smith</i>	
22. SIGNATURE OF DECEASED <i>John H. Smith</i>		23. SIGNATURE OF DECEASED <i>John H. Smith</i>		24. SIGNATURE OF DECEASED <i>John H. Smith</i>	
25. SIGNATURE OF DECEASED <i>John H. Smith</i>		26. SIGNATURE OF DECEASED <i>John H. Smith</i>		27. SIGNATURE OF DECEASED <i>John H. Smith</i>	
28. SIGNATURE OF DECEASED <i>John H. Smith</i>		29. SIGNATURE OF DECEASED <i>John H. Smith</i>		30. SIGNATURE OF DECEASED <i>John H. Smith</i>	
31. SIGNATURE OF DECEASED <i>John H. Smith</i>		32. SIGNATURE OF DECEASED <i>John H. Smith</i>		33. SIGNATURE OF DECEASED <i>John H. Smith</i>	
34. SIGNATURE OF DECEASED <i>John H. Smith</i>		35. SIGNATURE OF DECEASED <i>John H. Smith</i>		36. SIGNATURE OF DECEASED <i>John H. Smith</i>	
37. SIGNATURE OF DECEASED <i>John H. Smith</i>		38. SIGNATURE OF DECEASED <i>John H. Smith</i>		39. SIGNATURE OF DECEASED <i>John H. Smith</i>	
40. SIGNATURE OF DECEASED <i>John H. Smith</i>		41. SIGNATURE OF DECEASED <i>John H. Smith</i>		42. SIGNATURE OF DECEASED <i>John H. Smith</i>	
43. SIGNATURE OF DECEASED <i>John H. Smith</i>		44. SIGNATURE OF DECEASED <i>John H. Smith</i>		45. SIGNATURE OF DECEASED <i>John H. Smith</i>	
46. SIGNATURE OF DECEASED <i>John H. Smith</i>		47. SIGNATURE OF DECEASED <i>John H. Smith</i>		48. SIGNATURE OF DECEASED <i>John H. Smith</i>	
49. SIGNATURE OF DECEASED <i>John H. Smith</i>		50. SIGNATURE OF DECEASED <i>John H. Smith</i>		51. SIGNATURE OF DECEASED <i>John H. Smith</i>	
52. SIGNATURE OF DECEASED <i>John H. Smith</i>		53. SIGNATURE OF DECEASED <i>John H. Smith</i>		54. SIGNATURE OF DECEASED <i>John H. Smith</i>	
55. SIGNATURE OF DECEASED <i>John H. Smith</i>		56. SIGNATURE OF DECEASED <i>John H. Smith</i>		57. SIGNATURE OF DECEASED <i>John H. Smith</i>	
58. SIGNATURE OF DECEASED <i>John H. Smith</i>		59. SIGNATURE OF DECEASED <i>John H. Smith</i>		60. SIGNATURE OF DECEASED <i>John H. Smith</i>	
61. SIGNATURE OF DECEASED <i>John H. Smith</i>		62. SIGNATURE OF DECEASED <i>John H. Smith</i>		63. SIGNATURE OF DECEASED <i>John H. Smith</i>	
64. SIGNATURE OF DECEASED <i>John H. Smith</i>		65. SIGNATURE OF DECEASED <i>John H. Smith</i>		66. SIGNATURE OF DECEASED <i>John H. Smith</i>	
67. SIGNATURE OF DECEASED <i>John H. Smith</i>		68. SIGNATURE OF DECEASED <i>John H. Smith</i>		69. SIGNATURE OF DECEASED <i>John H. Smith</i>	
70. SIGNATURE OF DECEASED <i>John H. Smith</i>		71. SIGNATURE OF DECEASED <i>John H. Smith</i>		72. SIGNATURE OF DECEASED <i>John H. Smith</i>	
73. SIGNATURE OF DECEASED <i>John H. Smith</i>		74. SIGNATURE OF DECEASED <i>John H. Smith</i>		75. SIGNATURE OF DECEASED <i>John H. Smith</i>	
76. SIGNATURE OF DECEASED <i>John H. Smith</i>		77. SIGNATURE OF DECEASED <i>John H. Smith</i>		78. SIGNATURE OF DECEASED <i>John H. Smith</i>	
79. SIGNATURE OF DECEASED <i>John H. Smith</i>		80. SIGNATURE OF DECEASED <i>John H. Smith</i>		81. SIGNATURE OF DECEASED <i>John H. Smith</i>	
82. SIGNATURE OF DECEASED <i>John H. Smith</i>		83. SIGNATURE OF DECEASED <i>John H. Smith</i>		84. SIGNATURE OF DECEASED <i>John H. Smith</i>	
85. SIGNATURE OF DECEASED <i>John H. Smith</i>		86. SIGNATURE OF DECEASED <i>John H. Smith</i>		87. SIGNATURE OF DECEASED <i>John H. Smith</i>	
88. SIGNATURE OF DECEASED <i>John H. Smith</i>		89. SIGNATURE OF DECEASED <i>John H. Smith</i>		90. SIGNATURE OF DECEASED <i>John H. Smith</i>	
91. SIGNATURE OF DECEASED <i>John H. Smith</i>		92. SIGNATURE OF DECEASED <i>John H. Smith</i>		93. SIGNATURE OF DECEASED <i>John H. Smith</i>	
94. SIGNATURE OF DECEASED <i>John H. Smith</i>		95. SIGNATURE OF DECEASED <i>John H. Smith</i>		96. SIGNATURE OF DECEASED <i>John H. Smith</i>	
97. SIGNATURE OF DECEASED <i>John H. Smith</i>		98. SIGNATURE OF DECEASED <i>John H. Smith</i>		99. SIGNATURE OF DECEASED <i>John H. Smith</i>	
100. SIGNATURE OF DECEASED <i>John H. Smith</i>		101. SIGNATURE OF DECEASED <i>John H. Smith</i>		102. SIGNATURE OF DECEASED <i>John H. Smith</i>	

1933

FOR STATE  
HEALTH DEPT.

7653

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07631

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> <b>SPARROWS POINT</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>SPARROWS POINT Desp.</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>BALTIMORE</i> 3401-4	
d. STREET ADDRESS <i>1712 N. Bond St.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>RUFUS</i> Middle <i>MASON</i> Jr. Last <i>Jr.</i>		4. DATE OF DEATH Month <i>July</i> Day <i>2</i> Year <i>1959</i>	
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 10/1936</i>
9. AGE (In years last birthday) <i>23</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Greenville N.C.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>RUFUS MASON Sr.</i>		14. MOTHER'S MAIDEN NAME <i>EMMA Brewington</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or not known) <i>NO</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>MABLE MASON</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Accidental Electrocution</i> 914.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Chamber contact circuit while working</i>	
20c. TIME OF INJURY Month, Day, Year <i>7-2-1959</i>	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <i>Butt St. Co.</i>	20f. City or town <i>Baltimore</i> (County) <i>Baltimore</i> (State) <i>Md.</i>
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>M. B. Davis</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>M. B. Davis M.D.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>JULY 6/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>CARYCA MEM PARK</i>		22d. LOCATION (City, town, or county) (State) <i>LAUREL Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Melton E. Elckman</i>		ADDRESS <i>1129 N. Carbon St.</i>	
24a. REC'D BY REGISTRAR DATE <i>JUL 8 59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thayer</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

1853

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03681

DEATH OF

LOCALITY

NAME OF DECEASED  
MABLE MASON  
AGE  
SEX  
OCCUPATION  
CAUSE OF DEATH  
MANNER OF DEATH

1. Name of deceased	
2. Age	
3. Sex	
4. Occupation	
5. Cause of death	
6. Manner of death	
7. Signature of medical examiner	
8. Date	
9. Place	
10. Remarks	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7654 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07632

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTO.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>52 Catonsville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The New HAVEN Bd. &amp; CTN Co. BALTIMORE</b>		e. STREET ADDRESS <b>61 Winters Lane</b>	
3. NAME OF DECEASED (Type or print) <b>RAYMOND ELIAS MATTHEWS</b>		4. DATE OF DEATH <b>July 20<sup>th</sup> 1959</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>Neqro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Sept 15, 1900</b>
9. AGE (In years last birthday) <b>58</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FOLDING Boxes</b>	11. BIRTHPLACE (State or foreign country) <b>MD.</b>
12. CITIZEN OF WHAT COUNTRY? <b>American</b>		13. FATHER'S NAME <b>Charles Matthews</b>	
14. MOTHER'S MAIDEN NAME <b>Mary ADAMS.</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>216-14-2017</b>		17. INFORMANT <b>Raymond Eugene Matthews, #28</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>420.1</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>15 min?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>No injury</b>	
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>George H. Friskey</b>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>George H. FRISKEY, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7-24-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Western Star Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>James Hemley</b>		ADDRESS <b>578 N. Biddle St. Baltimore, Md.</b>	
24a. REC'D BY REGISTRAR <b>JUL 23 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7655 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **07633**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <input checked="" type="checkbox"/></span>															
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>			c. LENGTH OF STAY IN 1b  		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> <span style="float: right;"><b>3V01-4</b></span>														
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Lower dam, Loch Raven Dam</b>				d. STREET ADDRESS <b>906 Cathedral Street</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
<b>3. NAME OF DECEASED</b> (Type or print) First <b>WILLIAM</b> Middle <b>ARTHUR</b> Last <b>MC CARDELL</b>				<b>4. DATE OF DEATH</b> Month <b>July</b> Day <b>24</b> Year <b>19 59</b>															
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Oct. 30, 1942</b>		<b>9. AGE</b> (In years last birthday) <b>16</b> yrs.		<b>IF UNDER 1 YEAR</b> Months <b>16</b> Days <b>16</b> Hours <b>16</b> Min.									
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Clerk</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Newspaper</b>			<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>										
<b>13. FATHER'S NAME</b> <b>Paul J. McCardell, Sr.</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Emma Edwards</b>													
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b>				<b>16. SOCIAL SECURITY NO.</b> <b>216-40-0876</b>				<b>17. INFORMANT</b> <b>Paul McCardell, Sr., 3001 Delmar Ave. Baltimore 19, Md.</b>											
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia</b> DUE TO <b>drowning</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH																			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																			
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>Found drowned in Loch Raven Dam</b>															
<b>20c. TIME OF INJURY</b> Month, Day, Year <b>7/23/59</b> Hour <b>10</b> p. m.				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>Loch Raven Dam</b>				<b>20f. (City or town) (County) (State)</b> <b>Towson Baltimore Md.</b>							
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> <b>Accident</b> <input checked="" type="checkbox"/> <b>Suicide</b> <input type="checkbox"/> <b>Homicide</b> <input type="checkbox"/> <b>Undetermined cause</b> <input type="checkbox"/>																			
<b>ACTUAL SIGNATURE</b> <i>Charles S. Petty</i>						<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/>													
<b>EXAMINER'S NAME (Type)</b> <b>Charles S. Petty, M.D.</b>						<b>DATE SIGNED</b> <b>7/24/59</b>													
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>				<b>22b. DATE THEREOF</b> <b>7/27/59</b>				<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Ebenezer Methodist</b>				<b>22d. LOCATION (City, town, or county) (State)</b> <b>Chase Maryland</b>							
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Walter Brooks Bradley, Inc.</i>								<b>ADDRESS</b> <b>Dundalk 22</b>				<b>24a. REC'D BY REGISTRAR</b> <b>DATE</b> <b>JUL 28 '59</b>				<b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Kraus</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7656

CERTIFICATE OF DEATH

Reg. Dist. No.

07634

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>274 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> <b>3401-U</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>1429 John Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>PAUL</b> Middle <b>D.</b> Last <b>MC CLURE</b>				4. DATE OF DEATH Month <b>July</b> Day <b>16</b> Year <b>59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>May 31, 1899</b>		9. AGE (In years on birthday) <b>60</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pay Roll Clerk</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Steel Company</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				13. FATHER'S NAME <b>Louis R. McClure</b>			
14. MOTHER'S MAIDEN NAME <b>Jane E. Heath</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give year or dates of service) <b>WW I</b>			
16. SOCIAL SECURITY NO. <b>216-07-1270</b>				17. INFORMANT Address <b>Clin. Rec. Vet. Adm. Hospital, Fort Howard, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>EPENDYMOA OF CAUDA EQUINA WITH METASTASIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>5 YEARS</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. <b>7A</b> Month, Day, Year <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>October 15, 1958</b> , to <b>July 16, 1959</b> , and that death occurred at <b>11:05 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b> DATE SIGNED <b>7/17/59</b> ACTUAL SIGNATURE <b>John W. Crawford</b> M.D. <b>VAH, FORT HOWARD, MARYLAND</b> PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b> <b>VAH, FORT HOWARD, MARYLAND</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-20-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jenkins and Sons, Inc.</b>				ADDRESS <b>4905 York Road, Balto., Md.</b>		24a. REC'D BY REGISTRAR DATE <b>20 59</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles E. Thomas</b>							





TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7657

## CERTIFICATE OF DEATH

Reg. Dist. No.

07635

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>		c. LENGTH OF STAY IN 1b <b>31 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Academy Lane</b>				d. STREET ADDRESS <b>Academy Lane</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Joshua</b> Middle <b>Aquilla</b> Last <b>McComas</b>				4. DATE OF DEATH Month <b>July</b> Day <b>21</b> Year <b>1959</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan 9 1888</b>		9. AGE (In years last birthday) yrs. <b>71</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm helper</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Sommerville McComas</b>				14. MOTHER'S MAIDEN NAME <b>Annie Shipley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>220-05-9581</b>		17. INFORMANT <b>Mrs J A McComas Owings Mills Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>General arteriosclerosis</b> DUE TO (c) <b>four years</b>						INTERVAL BETWEEN ONSET AND DEATH <b>15 minutes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input checked="" type="checkbox"/> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-1-1930</b> to <b>7-21-59</b> , that I last saw the deceased alive on <b>7-21-59</b> , and that death occurred at <b>7:30</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>James G. Saffell</b> M.D.				DATE SIGNED <b>7-22-59</b>			
PHYSICIAN'S NAME (Type) <b>James G. Saffell MD</b>				ADDRESS (Street, city or town, state) <b>Reisterstown Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 24 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Deer Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Reisterstown Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Oliver L. Berryman</b>				ADDRESS <b>Reisterstown Md</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 24 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

## 250497

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7658

CERTIFICATE OF DEATH

07636

Reg. Dist. No. 32

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson</b>		c. LENGTH OF STAY IN 1b <b>1939-2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>		d. STREET ADDRESS <b>CALVARY SECTION</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>SADIE</b> Middle <b>CATHERINE</b> Last <b>McCREADY</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>1</b> Year <b>1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 21, 1886</b>
9. AGE (In years lost birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWORK</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11c. BIRTHPLACE (State or foreign country) <b>TANGIER ISLAND VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN DISE</b>		14. MOTHER'S MAIDEN NAME <b>LAURA PARKS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <b>Hospital Records, Mt. Wilson State Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA</b> <b>525X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) <b>PULMONARY FIBROSIS (UNDETERMINED ORIGIN)</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d) <b>SENILITY</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>4 yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4/20</b> , 19 <b>59</b> , to <b>7/1</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>7/1</b> , 19 <b>59</b> , and that death occurred at <b>1:15 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>William Newcomer</b> M.D.		Mt. Wilson, Maryland	
PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b>		Superintendent	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial July 4, 1959</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>Asbury</b>		22d. LOCATION (City, town, or county) (State) <b>Crisfield Ind.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James Henmon, Crisfield Ind.</b>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <b>JUL 7 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

100

Maryland STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
765 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 07637									
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>					c. LENGTH OF STAY IN 1b				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>27 N. Rolling Road</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>ELLEN</b> Middle <b>MAY</b> Last <b>McKEE</b>					4. DATE OF DEATH Month <b>July</b> Day <b>2</b> Year <b>1959</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/7/21</b>		9. AGE (In years last birthday) <b>38</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>School Board</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Louis Mayer</b>					14. MOTHER'S MAIDEN NAME <b>Ellen Whiteley</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or date of service)</b>					16. SOCIAL SECURITY NO.				
					17. INFORMANT <b>Edwin McKee</b> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Tofranil Poisoning.</b> <b>971.8</b> DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Ingested overdose of Tofranil</b>				
20c. TIME OF INJURY Hour <b>?</b> a. m. <b>?</b> p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>Catonsville</b> (County) <b>Baltimore</b> (State) <b>Md.</b>		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <b>Russell S. Fisher</b> M.D.					CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>				
EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			22b. DATE THEREOF <b>7/16/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Western</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Don</b> ADDRESS <b>28</b>					24a. REC'D BY REGISTRAR DATE <b>JUL 6 '59</b>		24b. REGISTRAR'S SIGNATURE <b>William S. Kline</b>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





7660

## CERTIFICATE OF DEATH

Reg. Dist. No.

07638

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 12</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1145 Stanmore Rd.</b>		d. STREET ADDRESS <b>1145 Stanmore Rd.</b>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Philip</b> Last <b>McMahon</b>		4. DATE OF DEATH Month <b>July</b> Day <b>18</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-5-1887</b>
9. AGE (In years last birthday) <b>72</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Gas &amp; Electric</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Bernard McMahon</b>		14. MOTHER'S MAIDEN NAME <b>Mary Connolly</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-05-5919</b>	
17. INFORMANT <b>Elizabeth McMahon</b>		Address <b>same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Crowning Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio Sclerosis</b> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Semingly</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 16, 1959</b> to <b>July 18, 1959</b> , that I last saw the deceased alive on <b>July 16, 1959</b> , and that death occurred at <b>5:20</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Alfred Byerly</b> M.D.		ADDRESS (Street, city or town, state) <b>3033 W. North Ave</b> DATE SIGNED <b>Boled 16 md</b>	
PHYSICIAN'S NAME (Type) <b>M Paul Byerly</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7-21-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Moreland Park Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 22 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

TO HOSPITAL: ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7661

## CERTIFICATE OF DEATH

Reg. Dist. No. 07639

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Presbyterian Home of Maryland</b>		d. STREET ADDRESS <b>2532 Arunah Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>KATHERINE</b> Middle <b>H.</b> Last <b>MEISTER</b>		4. DATE OF DEATH Month <b>July</b> Day <b>25</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 21, 1869</b>
9. AGE (In years last birthday) <b>90</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>J. Leonard Hoffman</b>		14. MOTHER'S MAIDEN NAME <b>Olivia Frances DeShields</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Records of Presbyterian Home</b>		Address <b>Towson, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Acute coronary occlusion</b> DUE TO <b>Arteriosclerotic cardiovascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>Arteriosclerotic cardiovascular disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January 1, 19 58</b> , to <b>July 25, 19 59</b> , that I last saw the deceased alive on <b>July 23, 19 59</b> , and that death occurred at <b>9:50 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7245 York Road</b> DATE SIGNED <b>July 25, 1959</b>			
ACTUAL SIGNATURE <b>S. J. Venable, Jr.</b>		M.D. <b>Baltimore 12, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>S. J. Venable, Jr. M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 28, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John O. Mitchell &amp; Sons Inc. 1900 Eutaw Place</b>		ADDRESS <b>1900 Eutaw Place</b>	
24a. REC'D BY REGISTRAR DATE <b>JUL 29 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Cirius S. Huns</b>	

CERTIFICATE OF DEATH

1921

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES M. WILSON		45		M		W		1876		Barnstable		Massachusetts		United States	
MARRIAGE		DATE		PLACE		CITY		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
Married		1900		Barnstable		Massachusetts		United States		1921		Barnstable		Massachusetts	
OCCUPATION		DATE		PLACE		CITY		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
Farmer		1921		Barnstable		Massachusetts		United States		1921		Barnstable		Massachusetts	
CAUSE OF DEATH		DATE		PLACE		CITY		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
Heart Disease		1921		Barnstable		Massachusetts		United States		1921		Barnstable		Massachusetts	
MANNER OF DEATH		DATE		PLACE		CITY		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
Natural		1921		Barnstable		Massachusetts		United States		1921		Barnstable		Massachusetts	
SIGNATURE OF PHYSICIAN		DATE		PLACE		CITY		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
J. M. Wilson		1921		Barnstable		Massachusetts		United States		1921		Barnstable		Massachusetts	
SIGNATURE OF REGISTRAR		DATE		PLACE		CITY		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
J. M. Wilson		1921		Barnstable		Massachusetts		United States		1921		Barnstable		Massachusetts	

7662

# CERTIFICATE OF DEATH

Reg. Dist. No.

07640

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Villa Nova</b>				c. LENGTH OF STAY IN 1b <b>X</b> <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Robb Nursing Home</b>				d. STREET ADDRESS <b>2112 Lorraine Avenue</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>SABILA</b> Middle <b>V.</b> Last <b>MELCHIOR</b>				4. DATE OF DEATH Month <b>July</b> Day <b>1</b> Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 12, 1868</b>		9. AGE (In years last birthday) <b>91</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Wilmington, Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Frederick Herting</b>				14. MOTHER'S MAIDEN NAME <b>M. Johanna Melchior</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. Rhoda I. Wagner-2112 Lorraine Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized arteriosclerosis with</b> <b>422.1</b> DUE TO <b>cardiovascular disease (old age)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>no</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>7/1</b> , 19 <b>59</b> , to <b>7/1</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>7/1</b> , 19 <b>59</b> , and that death occurred at <b>7:15</b> AM, from the causes and on the date stated above. * <b>DR ABBOTT</b> nurse <b>6/24/59</b> <b>DR M. SCHLENOFF</b> <b>6/29-6/30/59</b> ADDRESS (Street, city or town, state) <b>333 BEAUMONT AVE #28</b> DATE SIGNED <b>7/1/59</b> ACTUAL SIGNATURE <b>Matyas Relle</b> M.D. PHYSICIAN'S NAME (Type) <b>MATYAS RELLE</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/4/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ellsworth Armacost</b> ADDRESS <b>4600 Liberty Heights Ave.</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 6 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Christina L. K...</b>	

CERTIFICATE OF DEATH

1918

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]	
PLACE OF BIRTH [Faint text, possibly "Maryland"]		OCCUPATION [Faint text, possibly "Farmer"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]	
DATE OF DEATH [Faint text, possibly "Jan 15, 1918"]		TIME OF DEATH [Faint text, possibly "10:00 AM"]		PLACE OF DEATH [Faint text, possibly "Home"]	
SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF MINISTER [Faint signature]		SIGNATURE OF CORONER [Faint signature]	
COUNTY [Faint text, possibly "Baltimore"]		CITY [Faint text, possibly "Baltimore"]		STATE [Faint text, possibly "Maryland"]	



TO HOSPITAL. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7663  
CERTIFICATE OF DEATH

07641

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto. City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u> 4		c. LENGTH OF STAY IN 1b <u>4 1/2 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>College Manor aged home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>SARAH (SALLY) McPHERSON MIDDLETON</u>		4. DATE OF DEATH Month <u>July</u> Day <u>17</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1878</u>
9. AGE (in years last birthday) <u>86</u> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>S. Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas A. Middleton</u>		14. MOTHER'S MAIDEN NAME <u>May Beane</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Thomas F. Cadwalader, Jr.</u>		Address <u>Popa, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis = arterial insufficiency to legs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1955</u> , to <u>present</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July</u> , 19 <u>59</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ernest C. Brown Jr.</u>		DATE SIGNED <u>July 17, 59</u>	
PHYSICIAN'S NAME (Type)		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 20/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Green Mount</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Jenkins &amp; Sons Co.</u>		ADDRESS <u>4905 York Road</u>	
24a. REC'D BY REGISTRAR <u>Jul 20 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton R. Hume</u>	

# CERTIFICATE OF DEATH

7-63

<p>1. NAME OF DECEASED                  [Faint text]</p>		<p>2. SEX                  [Faint text]</p>	
<p>3. AGE                  [Faint text]</p>		<p>4. DATE OF BIRTH                  [Faint text]</p>	
<p>5. PLACE OF BIRTH                  [Faint text]</p>		<p>6. DATE OF DEATH                  [Faint text]</p>	
<p>7. CAUSE OF DEATH                  [Faint text]</p>		<p>8. MANNER OF DEATH                  [Faint text]</p>	
<p>9. SIGNATURE OF PHYSICIAN                  [Faint text]</p>		<p>10. SIGNATURE OF REGISTRAR                  [Faint text]</p>	
<p>11. SIGNATURE OF WITNESS                  [Faint text]</p>		<p>12. SIGNATURE OF DECEASED                  [Faint text]</p>	

MADE IN THE STATE OF NEW YORK  
 COUNTY OF [Faint text]  
 CITY OF [Faint text]  
 DECEASED [Faint text]  
 DATE OF DEATH [Faint text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7664

## CERTIFICATE OF DEATH

07642

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rossville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rossville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Box 280 Ridge Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Myrtle</b> Middle <b>W.</b> Last <b>Mohr</b>		4. DATE OF DEATH Month <b>July</b> Day <b>28</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 5, 1896</b>
9. AGE (In years last birthday) <b>63</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert Kuehne</b>		14. MOTHER'S MAIDEN NAME <b>Mary Hax</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mr. John Mohr</b>		Address <b>Box 280 Ridge Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>443X</b> IMMEDIATE CAUSE (a) <b>Hypertensive Cardiovascular Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1957</b> to <b>July 28, 1959</b> , that I last saw the deceased alive on <b>July 28, 1959</b> , and that death occurred at <b>11:35</b> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Louis Krause</b> M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 1, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Zion Lutheran</b>		22d. LOCATION (City, town, or county) (State) <b>Stemmers Run, Balto. Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lassahn Funeral Home</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 3 '59</b>	
ADDRESS <b>7401 Belair Rd.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>	

## 1

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07643

7665

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>4 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> 3401-4 d. STREET ADDRESS <b>334 SOUTH NORRIS STREET</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>A</b> Last <b>MOLESWORTH</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>6</b> Year <b>1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-24-94</b>
9. AGE (In years last birthday) <b>64</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TRUCK DRIVER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MOTOR TRANSFER CO</b>	
11. BIRTHPLACE (State or foreign country) <b>MT AIRY MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>EDWARD M MOLESWORTH</b>		14. MOTHER'S MAIDEN NAME <b>LILLIE M RUNKLES</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>218-14-8144</b>	
17. INFORMANT <b>CLIN REC VET ADM HOSP FT HOWARD MARYLAND</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SHOCK, INTRACTABLE</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CEREBRO-VASCULAR ACCIDENT</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>UNKNOWN</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>PNEUMONIA - Duration unknown</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 2</b> , 19 <b>59</b> , to <b>July 6</b> , 19 <b>59</b> , that death occurred at <b>5:45 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Armen Bogosian</b>		ADDRESS (Street, city or town, state) <b>VAH, Fort Howard, Md.</b>	
DATE SIGNED <b>7-6-59</b>			
PHYSICIAN'S NAME (Type) <b>Armen Bogosian</b>		M.D. <b>VAH, Fort Howard, Md.</b>	
7-6-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7/9/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>PROSPECT CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>FREDERICK COUNTY MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Olin M. Moleworth</b>		ADDRESS <b>Olin Moleworth Funeral Home, Damascus, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>JUL 8 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton S. Krause</b>	

VS A15 (4)  
15M 10/57

# CERTIFICATE OF DEATH

1865

<p>1. Name of deceased</p>		<p>2. Sex</p>	
<p>3. Age</p>		<p>4. Date of birth</p>	
<p>5. Place of birth</p>		<p>6. Date of death</p>	
<p>7. Cause of death</p>		<p>8. Place of death</p>	
<p>9. Signature of physician</p>		<p>10. Signature of registrar</p>	
<p>11. Date of registration</p>		<p>12. Place of registration</p>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07644

7666

## CERTIFICATE OF DEATH

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pikesville</u>			c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pikesville 8, Maryland</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>10 Walker Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Morris Pendleton Molesworth</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>July 6, 1959</u>			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>April 3, 1905</u>		<b>9. AGE</b> (In years last birthday) yrs. <u>54</u>	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Automotive Electric Sales</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Sales</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Mt. Airey, Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Louis C. Molesworth</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Nellie Frances Gaber</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>		<b>16. SOCIAL SECURITY NO.</b> <u>216-07-1962</u>		<b>17. INFORMANT</b> Address <u>Pikesville 8, Md</u> <u>Mrs. Mildred C. Molesworth, 10 Walker Ave</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arterio-sclerosis</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>5 hours</u> <u>8 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <u>19</u>	<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that I attended the deceased from</b> <u>Aug 4</u> , 19 <u>40</u> to <u>July 6</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 6</u> , 19 <u>59</u> , and that death occurred at <u>8:30</u> A.M. from the causes and on the date stated above.							
<b>ACTUAL SIGNATURE</b> <u>Palmer H. Williams</u> M.D.		<b>ADDRESS</b> (Street, city or town, state) <u>1725 Rustington Rd. Pikesville 8, Md.</u>		<b>DATE SIGNED</b> <u>July 7, 1959</u>			
<b>PHYSICIAN'S NAME</b> (Type) <u>Pikesville 8, Md.</u>							
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>22b. DATE THEREOF</b> <u>July 9, 1959</u>	<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Evergreen Memorials</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>Finksburg, Maryland</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Frank H. Newell</u>		<b>ADDRESS</b> <u>Pikesville 8, Md.</u>		<b>24a. REC'D BY REGISTRAR</b> DATE <u>JUL 10 '59</u>	<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>		

TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

5002

2nd DIST. NO.

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

EDUCATION

OCCUPATION

WILLIAM BOND

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
 5002  
 2nd DIST. NO.  
 DECEASED  
 DATE OF DEATH  
 PLACE OF DEATH  
 CAUSE OF DEATH  
 MANNER OF DEATH  
 EDUCATION  
 OCCUPATION  
 RELIGION  
 DATE OF BIRTH  
 PLACE OF BIRTH  
 DATE OF MARRIAGE  
 PLACE OF MARRIAGE  
 DATE OF DEATH  
 PLACE OF DEATH  
 CAUSE OF DEATH  
 MANNER OF DEATH  
 EDUCATION  
 OCCUPATION

7667

CERTIFICATE OF DEATH

Reg. Dist. No. 07645

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>White Hall</b>				c. LENGTH OF STAY IN 1b <b>60 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Levina</b> Middle <b>Ellen</b> Last <b>Moore</b>				4. DATE OF DEATH Month <b>July</b> Day <b>6</b> Year <b>1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 26, 1882</b>	
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Wilkenville, S. C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>J. Franklin Grant</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Elizabeth Davidson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>----</b>			
17. INFORMANT Address <b>Miss. Grace E. Moore White Hall, Md</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertension Cordiac Phrombo</b> DUE TO <b>443X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>1950</b> to <b>July 5</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>July 5</b> , 19 <b>59</b> , and that death occurred at <b>3:00 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>White Hall Md</b> DATE SIGNED <b>Milner Bortner</b> ACTUAL SIGNATURE <b>Milner Bortner</b> M.D. <b>White Hall Md</b> PHYSICIAN'S NAME (Type) <b>Milner Bortner</b> <b>White Hall, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/8/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Bethel</b>		22d. LOCATION (City, town, or county) (State) <b>Madonna Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles C. Kurtz</b>				ADDRESS <b>Garrettsville, Md.</b>		24a. REC'D BY REGISTRAR <b>JUL 10 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>							

07092

CERTIFICATE OF DEATH

1962

Belmont

Harvard

1000

White 101

30 years

White 101

July

White

White

White

8

White 101

8

White

White

U.S.A.

White 101

Home

White 101

White 101

White 101

White 101

10

1962

White 101

White 101

White 101

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7668

CERTIFICATE OF DEATH

Reg. Dist. No. 07646

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince George</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Owings Mills</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Seat Pleasant</i>	
c. LENGTH OF STAY IN 1b <i>2 month, 17 days</i>		16x-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Rosewood State Training School</i>		d. STREET ADDRESS <i>6612 Greig Street</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Patrick</i> Middle <i>Moore</i> Last <i>Moore</i>		4. DATE OF DEATH Month <i>7</i> Day <i>4</i> Year <i>19 59</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-16-59</i>
9. AGE (In years last birthday) yrs. <i>3</i> Months <i>17</i> Days <i>17</i> Hours <i></i> Min. <i></i>		IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S. A.</i>	
13. FATHER'S NAME <i>James R. Moore</i>		14. MOTHER'S MAIDEN NAME <i>Janet Frances Folks</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>James Moore, father.</i> Address <i>2-D.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hydrocephalus, marked with aspiration of stomach content</i> 752X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i></i>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <i>5:50 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>P. W. Rieckert</i> M.D.		ADDRESS (Street, city or town, state) <i>4307 Mainfield Ave</i> DATE SIGNED <i>7-4-59</i>	
PHYSICIAN'S NAME (Type) <i>P. W. Rieckert</i>		<i>Baltimore, Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>7-9-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Cem</i>	22d. LOCATION (City, town, or county) (State) <i>Washington, D.C.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. H. Chambers</i> ADDRESS <i>605 1/2 St. S.E. Wash. D.C.</i>		24a. REC'D BY REGISTRAR <i>JUL 10 '59</i> DATE	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>	



*[Faint, illegible text, likely a death certificate form with fields for name, date, and cause of death.]*

*[Faint, illegible text at the bottom of the page, possibly a signature or additional notes.]*



TO HOSPITAL - ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7549

CERTIFICATE OF DEATH

07647

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk (22)</b>		c. LENGTH OF STAY IN 1b <b>15 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>38 Broadship Road</b>		d. STREET ADDRESS <b>38 Broadship Road</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>GEORGE GRAHAM MORROW, Sr.</b>		4. DATE OF DEATH Month Day Year <b>July 27 1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 29, 1893</b>
9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cannery</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>William Morrow</b>		14. MOTHER'S MAIDEN NAME <b>Mary V. Ryle</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW # I 215-09-6260</b>	
17. INFORMANT <b>Mr. John Morrow-1952 Wareham Rd. ( 22 )</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>177X DUE TO</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <b>CH of Prostata</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7-27-59</b> , 19 <b>59</b> , to <b>7-27-59</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>7-27-59</b> , 19 <b>59</b> , and that death occurred at <b>7 p</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>J.C. Collins</b>		ADDRESS (Street, city or town, state) <b>3 Kinship Road- Baltimore 22, Md.</b>	
PHYSICIAN'S NAME (Type) <b>J.C. Collins, M.D.</b>		DATE SIGNED <b>7/28/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 30, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Co. Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WALTER BROOKS BRADLEY, INC. - DUNDALK</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 3 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>			



**X 1**  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**7669 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No.

**07648**

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville 52</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5 Rognel Ave</b>		d. STREET ADDRESS <b>5 Rognel Ave</b>	
3. NAME OF DECEASED (Type or print) First <b>Howard</b> Middle <b>W. Morsberger</b> Last <b></b>		4. DATE OF DEATH Month <b>July</b> Day <b>29</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-4-1899</b>
9. AGE (In years last birthday) <b>60 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bar Tender</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Liquors</b>	
11. BIRTHPLACE (State or foreign country) <b>Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Edward W. Morsberger</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. Espey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>William F. Morsberger. Catonsville Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Geo. S. M. Kieffer</b>		DATE SIGNED <b>July 30, 1959</b>	
EXAMINER'S NAME (Type) <b>Geo. S. M. Kieffer M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>8/1/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Landon Park</b>	22d. LOCATION (City, town, or county) (State) <b>Balto. Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hoff + Son</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 3 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoma</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and if any event within 72 hours after death.

STATE OF MARYLAND  
HEALTH DEPT.

1912

1912

MARYLAND STATE DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1912

Name of Deceased		Sex		Age		Date of Death	
Place of Birth		Place of Death		Cause of Death		Manner of Death	
Occupation		Education		Religion		Marital Status	
Previous Illnesses		Previous Injuries		Previous Operations		Previous Habits	
Time of Death		Time of Discovery		Time of Examination		Time of Burial	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Burial Officer	
Signature of Physician		Signature of Nurse		Signature of Undertaker		Signature of Cemetery	
Signature of Funeral Home		Signature of Burial Society		Signature of Religious Society		Signature of Other	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
Item 18 Film 245 7-28-59 ams											
7670											
CERTIFICATE OF DEATH											
Reg. Dist. No. 07649											
1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Phoenix</i>				c. LENGTH OF STAY IN 1b <i>43 yrs</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Phoenix</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Phoenix Rd</i>				d. STREET ADDRESS <i>Phoenix Rd</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Talmage</i> First <i>Mullenbore</i> Middle <i>James</i> Last				4. DATE OF DEATH <i>July 17 1959</i> Month <i>July</i> Day <i>17</i> Year <i>1959</i>							
5. SEX <i>Male</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>22 June 1890</i>		9. AGE (In years last birthday) <i>69</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Same</i>				11. BIRTHPLACE (State or foreign country) <i>Norristown, Tennessee</i>			
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>				13. FATHER'S NAME <i>Jefferson Mullenbore</i>				14. MOTHER'S MAIDEN NAME <i>Cardelia Wright</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i> (If yes, give war or dates of service) <i>1907-1911</i>				16. SOCIAL SECURITY NO. <i>218-01-507X</i>				17. INFORMANT <i>Wife</i> Address <i>Same</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cancer</i> 199.2 DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>primary site unknown</i> DUE TO											
(c) _____											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
				20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>1953</i> , to <i>July</i> , 1959, that I last saw the deceased alive on <i>10 July 1959</i> , and that death occurred at <i>1:30 P.M.</i> , from the causes and on the date stated above.											
ACTUAL SIGNATURE <i>Walter T. Kees</i>				M.D. <i>York Rd</i>				DATE SIGNED <i>16 July 1959</i>			
PHYSICIAN'S NAME (Type) <i>Walter T. KEES</i>				ADDRESS (Street, city or town, state) <i>Cockeysville, Md.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				22b. DATE THEREOF <i>7-20-59</i>				22c. NAME OF CEMETERY OR CREMATORY <i>Jessop Methodist</i>			
				22d. LOCATION (City, town, or county) (State) <i>Sparks, Md.</i>							
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS <i>Brooks Funeral Service, Towson 4, Md.</i>				24a. REC'D BY REGISTRAR DATE <i>JUL 21 '59</i>			
								24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kears</i>			





TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7671

## CERTIFICATE OF DEATH

Reg. Dist. No.

07650

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1500 Eastern Ave. Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Carolyn</b> Middle <b>Amelia</b> Last <b>Nagengast</b>		4. DATE OF DEATH Month <b>July</b> Day <b>7</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 2, 1944</b>
9. AGE (In years last birthday) <b>14</b> yrs.		IF UNDER 1 YEAR Months <b>14</b> Days <b>14</b> Hours <b>14</b> Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Joseph R. Nagengast</b>	
14. MOTHER'S MAIDEN NAME <b>Amelia Saint Cross</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Joseph R. Nagengast</b> Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b> <b>196.9</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of Bone</b> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <b>6 mo.</b> <b>15 mo.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 15</b> , 19 <b>59</b> , to <b>July 7</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>July 7</b> , 19 <b>59</b> , and that death occurred at <b>11:15A</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Joseph Miceli</b>		ADDRESS (Street, city or town, state) <b>108 S. Taylor Avenue</b> DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>Joseph Miceli, M.D.</b>		<b>Baltimore 21, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7/10/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore Co., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>James Bruzdinski</b> ADDRESS <b>1407 Eastern Ave. Rd.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 13 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

# CERTIFICATE OF DEATH

MINNESOTA STATE DEPARTMENT OF HEALTH - MINNEAPOLIS, MINN.

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		1928		MOBILE, ALA.	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		DATE OF DEATH		PLACE OF DEATH	
1000 ...		...		...		...		4/4/68		MEMPHIS, TENN.	
CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.		REGISTRATION NO.		DATE OF REGISTRATION		PLACE OF REGISTRATION	
...		...		...		...		...		...	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF ...	
...		...		...		...		...		...	

TO HOSPITAL—ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7672

## CERTIFICATE OF DEATH

Reg. Dist. No.

07652

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7209 WOODROW AVE</u>		d. STREET ADDRESS <u>7209 WOODROW AVE. (24)</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOSEPH C NEUSCHAFER</u>		4. DATE OF DEATH Month Day Year <u>JULY 7 19 59</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-5-1898</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED (BANK)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN NEUSCHAFER</u>		14. MOTHER'S MAIDEN NAME <u>MOLLIE BECK</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>ELSIE NEUSCHAFER</u>		Address <u>7209 WOODROW AVE. (24)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>DIABETES MELLITUS</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>10 MIN.</u> <u>15 years</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/10/57</u> , 19____, to <u>7/7/59</u> , 19____, that I last saw the deceased alive on <u>7/7/59</u> , 19____, and that death occurred at <u>11:50 A.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Max Baum</u> M.D. <u>7422 Eastern Ave</u> PHYSICIAN'S NAME (Type) <u>MAX BAUM</u> <u>Baltimore</u> <u>Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-11-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ZION LUTHERAN</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John S. Connelly</u>		ADDRESS <u>418 Eastern Blvd. (21)</u>	
24a. REC'D BY REGISTRAR DATE <u>JUL 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton J. ...</u>	



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7673  
CERTIFICATE OF DEATH

07653

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balt.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balt.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	c. LENGTH OF STAY IN <u>2 mon. 12 day</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balt.</u> <u>3401-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hospital</u>		d. STREET ADDRESS <u>1928 W. Fayette St.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>MARGARET COLLINS NICKLES</u>		4. DATE OF DEATH <u>July 4 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-23-94</u>
9. AGE (In years last birthday) <u>64</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>	11. BIRTHPLACE (State or foreign country) <u>Md</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Charles Collins</u>		14. MOTHER'S MAIDEN NAME <u>Anna Kraft</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>Hospital Records</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Infarctive myocardial fibrosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>Generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>?</u> <u>years</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		

21. I certify that I attended the deceased from 4/22/59, 1959, to 7/4/59, 1959, that I last saw the deceased alive on 7/4/59, 1959, and that death occurred at 5 P.M., from the causes and on the date stated above.

ADDRESS (Street, city or town, state) Spring Grove St. Hosp DATE SIGNED 7-5-1959

ACTUAL SIGNATURE Gertrude J. Fleischmann M.D.

PHYSICIAN'S NAME (Type) GERTRUDE J. FLEISCHMANN

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>7-8-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MORCLAND PARK</u>	22d. LOCATION (City, town, or county) <u>BALTO</u> (State) <u>Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard Ruck</u> ADDRESS <u>5305 Harford</u>		24a. REC'D BY REGISTRAR <u>JUL 7 '59</u>	24b. REGISTRAR'S SIGNATURE <u>John B. Frank</u>





TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours of death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

1

090

1

DP

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7674

CERTIFICATE OF DEATH

Reg. Dist. No.

07654

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>House in Pines, 16 Fusting Ave.</b>		d. STREET ADDRESS <b>407 Normandy Ave</b>	
3. NAME OF DECEASED (Type or print) First <b>Michael</b> Middle <b>J.</b> Last <b>O'Brien</b>		4. DATE OF DEATH Month <b>July</b> Day <b>7</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 5, 1874</b>
9. AGE (In years last birthday) <b>84</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Supervisor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Spring Grove</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Michael O'Brien</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Daly</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>Informant (daughter) Miss Veronica O'Brien, 407 Normandy Ave</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA FACE</b> <b>191.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>2 YRS</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>JAN. 1955</b> to <b>7/7 1959</b> that I last saw the deceased alive on <b>7/7 1959</b> , and that death occurred at <b>7 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3629 Edmondson Ave Baltimore, 29, Md</b> DATE SIGNED			
ACTUAL SIGNATURE <b>Thos E Roach</b> M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>Thos E Roach</b>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 10/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore 29, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke Funeral Directors, 4101 Edmondson Ave</b>		24a. REC'D BY REGISTRAR <b>JUL 10 1959</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. H...</b>			

CERTIFICATE OF DEATH

1974

Baltimore

Baltimore

Catonsville

Baltimore

Home in 1962, 15 Easting Ave.

Michael J. O'Brien

White male

Resided 15 Easting Ave., Catonsville, Maryland.

Residence

Michael O'Brien

Residence

Miss Veronica O'Brien, 407 Kermanshah Ave.

Catonsville, Md.

Resided 15 Easting Ave., Catonsville, Md.

Residence 15 Easting Ave., Catonsville, Md.

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or officiating physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the officiating physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7675

## CERTIFICATE OF DEATH

07655

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Towson</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rural Towson</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Glenarm Road</b>				/d. STREET ADDRESS <b>Glenarm Road</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Sister Mary Ignace O'Mara</b>				4. DATE OF DEATH Month Day Year <b>July 27 1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 17, 1900</b>	
9. AGE (In years last birthday) <b>59</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>RELIGIOUS.</b>		11. BIRTHPLACE (State or foreign country) <b>Short Hills New Jersey</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Joseph O'Mara</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Kehoe</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <input type="checkbox"/>		17. INFORMANT <b>Sister M. Peter Fourier</b>		Address <b>Notch Cliff, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized cancer</b> DUE TO (b) <b>Cancer of breast</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>170X</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>170X</b> INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>April</b> , 19 <b>59</b> , to <b>July</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>July 21</b> , 19 <b>59</b> , and that death occurred at <b>11:00 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7501 York Road Towson 4, Md.</b> DATE SIGNED <b>7/28/59</b> ACTUAL SIGNATURE <b>Charles F. O'Donnell M.D.</b> PHYSICIAN'S NAME (Type) <b>Charles F. O'Donnell M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7-30-59.</b>		22c. NAME OF CEMETERY OR CREMATORY <b>VILLA MARIA CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>NOTCH CLIFF NR TOWSON, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles A. Geller</b> ADDRESS <b>901 S. CONKLING ST. BALTO., 24, MD.</b>				24a. REC'D BY REGISTRAR <b>JUL 30 '59</b>		24b. REGISTRAR'S SIGNATURE <b>William P. H.</b>	

100000

WILLIAM BOND

CERTIFICATE OF DEATH

100000

100000

100000

100000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7676

CERTIFICATE OF DEATH

Reg. Dist. No.

07656

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>52 Catonsville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>3 Melvin Ave</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Tillie</b> Middle <b>Anna</b> Last <b>Paetow</b>				4. DATE OF DEATH Month <b>7</b> Day <b>2--</b> Year <b>19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-13-1872</b>	
9. AGE (In years last birthday) <b>86</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Buyer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dept. Store</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>Emil Paetow</b>		14. MOTHER'S MAIDEN NAME <b>Katherine Schell</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		INFORMANT <b>Frank Garich</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>442 X</b> DUE TO <b>Quinocular fibrillation</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Cardio-Vascular Renal Disease</b> (c) <b>1 week 8 yrs?</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3.14</b> , 19 <b>51</b> to <b>7.2</b> , 19 <b>59</b> that I last saw the deceased alive on <b>7.2</b> , 19 <b>59</b> , and that death occurred at <b>4 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>George E. Urban</b>				DATE SIGNED <b>805 2nd. Ave. 28th Md 7.2.59</b>			
PHYSICIAN'S NAME (Type) <b>George E. Urban</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-6-1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. J. ...</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 7 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. ...</b>	

MEDICAL CERTIFICATION

00000

OFFICE OF THE ATTORNEY GENERAL

1913



State of Maryland  
County of Baltimore

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe



7677

## CERTIFICATE OF DEATH

Reg. Dist. No.

07657

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>3 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>H</b> Last <b>PARKER</b>				4. DATE OF DEATH Month <b>July</b> Day <b>29</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 19, 1876</b>	
9. AGE (In years last birthday) yrs. <b>83</b>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Naval Academy</b>		11. BIRTHPLACE (State or foreign country) <b>Annapolis, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Charlotte MN: Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>SAW</b>			
17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBROVASCULAR ACCIDENT (CEREBRAL THROMBOSIS)</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROSIS, GENERALIZED</b> DUE TO (c) <b>UNKNOWN</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>July 26</b> , 19 <b>59</b> , to <b>July 29</b> , 19 <b>59</b> , and that death occurred at <b>7:45 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John W. Crawford</b>				ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b>			
DATE SIGNED <b>7/30/59</b>							
PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b>				VAH, FORT HOWARD, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-3-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Anne. Hall</b>		22d. LOCATION (City, town, or county) (State) <b>Annapolis, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Reese Mortuary 108 W. Washington St. Annapolis, Md.</b>				24a. REC'D BY REGISTRAR <b>AUG 3 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Reese</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CONFIDENTIAL

7577

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

7550

# CERTIFICATE OF DEATH

Reg. Dist. No.

07658

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk (22)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>53 Dundalk (22)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6826 Dunbar Road</b>		d. STREET ADDRESS <b>6826 Dunbar Road</b>	
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>FRANK</b> Last <b>PAUKNER</b>		4. DATE OF DEATH Month <b>July</b> Day <b>30</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 27, 1895</b>
9. AGE (In years last birthday) yrs. <b>63</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Millwright Foreman-Steel</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Pennsylvania</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph Paukner</b>		14. MOTHER'S MAIDEN NAME <b>Maria (unknown)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-07-0641</b>	
17. INFORMANT <b>Mrs. Robert Clark-3485 Dunhaven Rd. 22</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Arteriosclerotic Heart Disease</b> DUE TO <b>Disease</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>10 min</b> <b>8 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan. 1, 1957</b> , to <b>July 30, 1959</b> , that I last saw the deceased alive on <b>July 24, 1957</b> , and that death occurred at <b>12:55 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Eugene R. Evans, M.D.</b> <b>7-31-59</b>			
ACTUAL SIGNATURE <b>Eugene R. Evans, M.D.</b>		PHYSICIAN'S NAME (Type) <b>1 Liberty Parkway-Dundalk 22, Md.</b>	
22a. BURIAL, CREMATION, REBURY (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 3, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Co. Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Brooks Bradley, Inc., Dundalk</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 3 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

• **Interpretation**

1  
#  
M  
050  
1  
TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7678  
CERTIFICATE OF DEATH

Reg. Dist. No.

07659

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>174 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>STEWART</b> Middle <b>O.</b> Last <b>PETERS</b>				4. DATE OF DEATH Month <b>July</b> Day <b>10</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>September 25, 1895</b>	
9. AGE (In years last birthday) yrs. <b>63</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Operator</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Samuel Peters</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Meyers</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW I 217-09-8226</b>		17. INFORMANT <b>Clin. Rec. Vet. Adm. Hospital, Ft. Howard, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>EXCAVATING CARCINOMA, RIGHT UPPER LOBE, WITH SOLITARY METASTASIS TO LIVER.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>DOES</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>January 17, 1959</b> , to <b>July 10, 1959</b> , and that death occurred at <b>8:50 A. M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b> DATE SIGNED <b>7/10/59</b>							
ACTUAL SIGNATURE <b>Donald D. Mark</b>				PHYSICIAN'S NAME (Type) <b>DONALD D. MARK, M. D., PATRICIA COYST</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-14-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Blight, Inc.</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 14 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

100-100000

CERTIFICATE OF DEATH

1970

Name of Deceased		Date of Birth		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar		Signature of Witness	
John Doe		10-10-1920		Male		White		Married		Teacher		Heart Disease		Home		10-10-1970		10:00 AM		[Signature]		[Signature]		[Signature]	
Date of Death		Time of Death		Place of Death		Cause of Death		Occupation		Marital Status		Race		Sex		Date of Birth		Name of Deceased		Signature of Physician		Signature of Registrar		Signature of Witness	
10-10-1970		10:00 AM		Home		Heart Disease		Teacher		Married		White		Male		10-10-1920		John Doe		[Signature]		[Signature]		[Signature]	



TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7679

## CERTIFICATE OF DEATH

07660

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>80 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ROBERT</b> First Middle Lost <b>----- PINN</b>		4. DATE OF DEATH Month <b>July</b> Day <b>12</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 28, 1893</b>
9. AGE (In years and birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Metal Company</b>	
11. BIRTHPLACE (State or foreign country) <b>Warrenton, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Robert Pinn</b>		14. MOTHER'S MAIDEN NAME <b>Lena Campbell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO. <b>217-03-4616</b>	
17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Fort Howard, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ADENOCARCINOMA OF RECTUM</b> <b>154X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CEREBROVASCULAR ACCIDENT (CLINICAL)</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>6 MONTHS</b> <b>3 MONTHS</b>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>19 59</b> Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 23</b> , 19 <b>59</b> , to <b>July 12</b> , 19 <b>59</b> and that death occurred at <b>3:35A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b> DATE SIGNED <b>7/13/59</b>			
ACTUAL SIGNATURE <b>Thomas F. Crahan</b>		PHYSICIAN'S NAME (Type) <b>THOMAS F. CRAHAN, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/15/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arlington S. Phillips</b>		ADDRESS <b>1808-10 N. Monroe St. Balto. 17, Md.</b>	
24a. REC'D BY REGISTRAR <b>JUL 22 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton S. Kraus</b>	

0330

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

CERTIFICATE OF DEATH

1973

Name		Last Name		First Name		Middle Name	
John		Doe		Robert		Lee	
Date of Birth		Sex		Race		Religion	
10-15-1925		Male		White		Roman Catholic	
Place of Birth		Usual Residence		Cause of Death		Manner of Death	
Baltimore, Maryland		Baltimore, Maryland		Heart Disease		Natural	
Date of Death		Time of Death		Place of Death		Physician	
10-20-1973		10:30 AM		Home		Dr. J. A. Smith	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner	
[Signature]		[Signature]		[Signature]		[Signature]	
Official Seal		Official Seal		Official Seal		Official Seal	
[Seal]		[Seal]		[Seal]		[Seal]	
Date of Entry		Time of Entry		Place of Entry		Physician	
10-21-1973		11:00 AM		Hospital		Dr. J. A. Smith	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner	
[Signature]		[Signature]		[Signature]		[Signature]	
Official Seal		Official Seal		Official Seal		Official Seal	
[Seal]		[Seal]		[Seal]		[Seal]	

7680

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

07661

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills, Md.</b>				c. LENGTH OF STAY IN TB <b>23 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rosewood State Training School</b>				d. STREET ADDRESS <b>formerly of</b> <b>2338 N. Calvert Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Katherine</b> Middle <b>Rosalie</b> Last <b>Porter</b>				4. DATE OF DEATH Month <b>7</b> Day <b>22</b> Year <b>19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/28/23</b>		9. AGE (In years last birthday) <b>35</b> yrs.	IF UNDER 1 YEAR Months <b>7</b> Days <b>22</b> Hours <b>19</b> Min. <b>59</b>	IF UNDER 24 HRS. Months <b>7</b> Days <b>22</b> Hours <b>19</b> Min. <b>59</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harry P. Porter - deceased</b>				14. MOTHER'S MAIDEN NAME <b>Ethel Grace Bailey - deceased</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>---</b>		INFORMANT <b>Rosewood Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple pulmonary emboli</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterial dysentery with colon perforation</b> DUE TO (c) <b>Arterial dysentery with colon perforation</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <b>12:40 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4307 Marlfield Ave, Baltimore</b> DATE SIGNED <b>7/22/59</b>							
ACTUAL SIGNATURE <b>Dr. W. Beckard</b> M.D.				PHYSICIAN'S NAME (Type) <b>P. W. Rieckert</b> <b>4307 Marlfield Ave, Baltimore</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/24/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Union Chapel Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Wilna, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. F. Pickner &amp; Sons, No. 8 Pa. Ave., Balto., Md.</b>				24a. REC'D BY REGISTRAR <b>JUL 23 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

03001

7680

CERTIFICATE OF DEATH

NAME OF DECEASED  
DATE OF DEATH  
PLACE OF DEATH

AGE

SEX

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

SEX

AGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

AGE

SEX

AGE

SEX

AGE

SEX

AGE

SEX

AGE

SEX

AGE

SEX

AGE

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7681 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07662

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55 TOWSON</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PARKTON, MD.</u>		1. d. STREET ADDRESS <u>108 E. CHESAPEAKE AVE</u>	
3. NAME OF DECEASED (Type or print) First <u>MILTON H.</u> Middle <u>POWELL</u> Last <u>POWELL</u>		4. DATE OF DEATH Month <u>7</u> Day <u>4</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 6, 1915</u>
9. AGE (In years last birthday) <u>43</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM HAND</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	11. BIRTHPLACE (State or foreign country) <u>MD</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>ERNEST POWELL</u>	
14. MOTHER'S MAIDEN NAME <u>SARAH DIGGS</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>UN KNOWN</u>		17. INFORMANT <u>SARAH CAUSION - 108 E. CHESAPEAKE AVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushing Injury to Skull</u> 802x DUE TO <u>with Hemiparesis Multiple</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Fractures</u> (b) <u>  </u> (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Sitting on track when train passed</u>		20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour o. m. <u>  </u> p. m. <u>  </u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. (City or town) <u>  </u>		(County) <u>  </u> (State) <u>  </u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Charles F. Donnell</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>  </u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>  </u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/8/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>STEPHENSON CHAPEL</u>		22d. LOCATION (City, town, or county) (State) <u>SPARKS, BALTO. CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. I. Chatman Jr.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 9 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>  </u>		24c. REGISTRAR'S SIGNATURE <u>  </u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death.

1. The first part of the paper is devoted to the study of the asymptotic behavior of the solutions of the system of equations (1) as  $\epsilon \rightarrow 0$ . It is shown that the solutions of the system (1) converge to the solutions of the system (2) in the sense of the weak convergence of measures. The second part of the paper is devoted to the study of the asymptotic behavior of the solutions of the system (1) as  $\epsilon \rightarrow 0$ . It is shown that the solutions of the system (1) converge to the solutions of the system (2) in the sense of the weak convergence of measures.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7682 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07663

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Balto. City</u></span>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparrows Point 19, Md.</u>		c. LENGTH OF STAY IN 1b  	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1317 N. Broadway Sparrows Pt.</u>		d. STREET ADDRESS <u>1317 N. Broadway</u>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>George</u> Middle <u>Pride</u> Last <u>Pride</u>		<b>4. DATE OF DEATH</b> Month <u>7</u> Day <u>10</u> Year <u>19 59</u>	
<b>5. SEX</b> <u>male</u>	<b>6. COLOR OR RACE</b> <u>colored</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>6/1/05</u>
<b>9. AGE</b> (In years last birthday) <u>54</u> yrs.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Hot Blast Man</u>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Steel Ind.</u>
<b>11. BIRTHPLACE</b> (State or foreign country) <u>Mechanic Co Va.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>Am.</u>	
<b>13. FATHER'S NAME</b> <u>Samuel Pride</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Beth Pride</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>227 10 2674</u>	
<b>17. INFORMANT</b> Address <u>Wife - 1317 N. Broadway</u>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rheumatic Carditis</u> <u>416X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) _____ DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>	
<b>20c. TIME OF INJURY</b> Hour <u>19</u> a. m. _____ p. m. _____ Month, Day, Year _____	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____	<b>20f. (City or town)</b> _____ (County) _____ (State) _____
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
<b>ACTUAL SIGNATURE</b> <u>M B Davis</u>		<b>DATE SIGNED</b> <u>7-10-59</u>	
<b>EXAMINER'S NAME (Type)</b> <u>M. B. Davis, M. D.</u>		<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>	<b>22b. DATE THEREOF</b> <u>7/14/59</u>	<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Carroll Memorial Cem. Laurel Md.</u>	<b>22d. LOCATION (City, town, or county)</b> _____ (State) _____
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Theodore W Long</u>		<b>24a. REC'D BY REGISTRAR</b> DATE <u>7/14/59</u>	
<b>ADDRESS</b> <u>2700 Edmondson ave</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kneave</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR FUNERAL PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

VS A15 (4)  
15M 9/58

7683

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

07664

1. PLACE OF DEATH o. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Overlea</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Overlea</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>5510 Kenwood Ave.</i>		d. STREET ADDRESS <i>5510 Kenwood Ave.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Ella</i> Middle <i>Nora</i> Last <i>Rauck</i>		4. DATE OF DEATH Month <i>7</i> Day <i>19</i> Year <i>59</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-20-1890</i>
9. AGE (In years last birthday) <i>69</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>William Weaver</i>		14. MOTHER'S MAIDEN NAME <i>Lucy C. Myers</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>INFORMANT</i> <i>Carl E. Rauck</i> Address <i>same</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Occlusion</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <i>Arteriosclerotic Cardiovascular Disease</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>April 14, 1958</i> to <i>July 19, 1959</i> that I last saw the deceased alive on <i>July 19, 1959</i> and that death occurred at <i>7:30 PM</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Samuel B. Wolfe</i>		ADDRESS (Street, city or town, state) <i>1331 E. North Ave. Balto City, Maryland</i>	
PHYSICIAN'S NAME (Type) <i>SAMUEL B. WOLFE</i>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>7-23-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		ADDRESS <i>5305 Harford Rd.</i>	
24a. REC'D BY REGISTRAR DATE <i>JUL 22 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

1000

CERTIFICATE OF DEATH

1000

1. Name of deceased  
2. Sex  
3. Age  
4. Date of birth  
5. Date of death  
6. Place of death  
7. Cause of death  
8. Signature of physician  
9. Signature of registrar  
10. Date of registration

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

7684

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

07665

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>55 Towson</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>612 Dunkirk Rd.</i>		d. STREET ADDRESS <i>612 Dunkirk Rd.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Katherine</i> Middle <i>Rauschenbach</i> Last <i></i>		4. DATE OF DEATH Month <i>July</i> Day <i>27</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-26-1883</i>
9. AGE (In years last birthday) <i>75</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i></i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Valentine Goeb</i>		14. MOTHER'S MAIDEN NAME <i>Caroline Kleper</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>216-10-8942</i>	
17. INFORMANT <i>John Rauschenbach</i> Address <i>same</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Pancreas</i> <i>157x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <i>o. m.</i> <i>19</i> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>March 1955</i> to <i>July 1959</i> , that I lost saw the deceased alive on <i>7/27/59</i> , 19 <i>59</i> , and that death occurred at <i>7:30 P.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>6305 Harford Rd. Balt. Md.</i> DATE SIGNED <i>7/29/59</i>	
ACTUAL SIGNATURE <i>W. M. Smith</i> M.D.			
PHYSICIAN'S NAME (Type) <i>W. M. Smith</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7/30/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i> ADDRESS <i>5305 Harford Rd.</i>		24a. REC'D BY REGISTRAR DATE <i>JUL 28 '59</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

41265

CERTIFICATE OF BIRTH

1904

Name of Child		John William	
Date of Birth		1904	
Place of Birth		New York	
Sex		Male	
Color		White	
Height		5 ft 10 in	
Weight		150 lbs	
Build		Medium	
Eyes		Blue	
Hair		Brown	
Skin		Fair	
Mental		Normal	
Physical		Normal	
Social		Normal	
Religious		None	
Education		None	
Occupation		None	
Marital Status		Single	
Parents		John & Mary	
Address		New York	
Signature		[Signature]	
Date		1904	



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4

7685

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07666

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>55 Towson</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>100 W. Susquehanna Avenue</b>		/d. STREET ADDRESS <b>100 W. Susquehanna Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>NELLIE DUNCAN RAWLINGS</b>		4. DATE OF DEATH Month Day Year <b>July 8, 1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 17, 1874</b>
9. AGE (In years last birthday) <b>84</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John D. C. Duncan</b>		14. MOTHER'S MAIDEN NAME <b>Catherine E. Jones</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Family records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO <b>Arteriosclerosis Cerebral &amp; Heart with</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>332 X</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9/8</b> , 19 <b>58</b> , to <b>7/8</b> , 19 <b>59</b> , that I lost s/he the deceased alive on <b>7/8</b> , 19 <b>59</b> , and that death occurred at <b>1207</b> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED <b>Bennett A. Stoen M.D. 19 W. Seminary Ave. Cockeysville 7/10/59</b>	
ACTUAL SIGNATURE <b>Bennett A. Stoen</b>		PHYSICIAN'S NAME (Type) <b>Bennett A. Stoen</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>July 11, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Jessop's Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Cockeysville, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns' Sons, Towson, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 14 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>

MEDICAL CERTIFICATION

1958

1958

Belmont

Belmont

Belmont

London

London

100 N. Washington Avenue

100 N. Washington Avenue

July 8, 1958

WILLIAM DENNIS RAYMOND

NY

July 19, 1958

NY

WILLIAM DENNIS RAYMOND

NY

WILLIAM DENNIS RAYMOND

NY

WILLIAM DENNIS RAYMOND

WILLIAM DENNIS RAYMOND

WILLIAM DENNIS RAYMOND

WILLIAM DENNIS RAYMOND

NY

NY

NY

WILLIAM DENNIS RAYMOND

WILLIAM DENNIS RAYMOND

WILLIAM DENNIS RAYMOND

WILLIAM DENNIS RAYMOND

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7686 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
CERTIFICATE OF DEATH										
Reg. Dist. No. 07667										
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills			c. LENGTH OF STAY IN 1b 10 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Dolfield Road					d. STREET ADDRESS Dolfield Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last George Albert Redding					4. DATE OF DEATH Month Day Year July 31, 1959					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH May 1, 1878		9. AGE (In years last birthday) 81 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tile & Marble Setter			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A		
13. FATHER'S NAME Frederick Redding					14. MOTHER'S MAIDEN NAME Ellen Weaver					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 213-10-5765		17. INFORMANT Vernon A. Redding			Address Owings Mills		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 181.0 Carcinoma - bladder DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 7 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. 19			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from January 1959, to July 31, 1959, that I last saw the deceased alive on July 31, 1959, and that death occurred at 6:30 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Plummers E. Williams M.D. Keisterstown, Maryland July 31, 1959 PHYSICIAN'S NAME (Type)										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF Aug. 3, 1959		22c. NAME OF CEMETERY OR CREMATORY St. Mary's (Hampden)		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Burgee Funeral Home Horace F. Burgee					ADDRESS 3631 Falls Road		24a. REC'D BY REGISTRAR DATE AUG 3 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



101-205-200

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7687  
CERTIFICATE OF DEATH

07668

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>13 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b> 02x-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>RFD 2, Box 532</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>E.</b> Last <b>REDMOND</b>				4. DATE OF DEATH Month <b>July</b> Day <b>5</b> Year <b>59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 4, 1899</b>	
9. AGE (In years lost birthday) <b>60 yrs.</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffeur</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Taxi Cab</b>		11. BIRTHPLACE (State or foreign country) <b>St. Mary's Co. Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>John F. Redmond</b>		14. MOTHER'S MAIDEN NAME <b>Ida Bond</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW I 139-09-4797</b>		17. INFORMANT <b>Clin. Records. Vet. Adm. Hosp. Ft. Howard, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ENLARGEMENT OF HEART WITH CONGESTIVE FAILURE</b> 527.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CYSTIC DISEASE OF LUNG</b> DUE TO (c) <b>PULMONARY EMPHYSEMA</b>				INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>UNKNOWN</b> <b>UNKNOWN</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>June 22, 1959</b> to <b>July 5, 1959</b> and that death occurred at <b>11:45 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Fort Howard, Md.</b> DATE SIGNED <b>7-5-59</b>							
ACTUAL SIGNATURE <b>George C. McElPatrick</b> M.D.				PHYSICIAN'S NAME (Type) <b>GEORGE C. McELPATRICK, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>08 July 59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>	
22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>				22e. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>SINGLETON FUNERAL HOME, 200 Crain Highway</b>				ADDRESS <b>Glen Burnie, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 8 59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knapp</b>				24c. REGISTRAR'S SIGNATURE <b>Arthur S. Knapp</b>			

# CERTIFICATE OF DEATH

MADE AND STATED AT THE OFFICE OF HEALTH - BALTIMORE, MD.

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917



TO HOSPITAL - ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7688

CERTIFICATE OF DEATH

Reg. Dist. No.

07669

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annastie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annastie</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>at home</u>		d. STREET ADDRESS <u>502 Annastie Rd</u>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Hazel Michael Reid</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>July-1-1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July-10-1898</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Woonsocket, R.I.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thomas Michael</u>		14. MOTHER'S MAIDEN NAME <u>Carrie Frost</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>G.M. Reid-Husband</u>		Address <u>502 Annastie</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rheumatic Heart Disease -</u> <u>410X</u> DUE TO <u>Mitral Stenosis and Druffiaemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic urinary tract infection</u>			INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1947</u> , 19 <u>711</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6/30</u> , 19 <u>59</u> , and that death occurred at <u>5:20 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>11 E. Chase St Baltimore 2 Md</u> DATE SIGNED <u>7/2/59</u>			
ACTUAL SIGNATURE <u>Martin T. Singewald</u> M.D.		PHYSICIAN'S NAME (Type) <u>MARTIN T. SINGEWALD M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried July 3/59</u>		22b. DATE THEREOF <u>July 3/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore-2-Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Stewart M. Moore</u>		ADDRESS <u>108 W. North St</u>	
24a. REC'D BY REGISTRAR <u>JUL 6 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Carroll L. Hume</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED <b>MARTIN, J. J.</b>		2. SEX <b>MALE</b>	
3. DATE OF BIRTH <b>1911-11-11</b>		4. PLACE OF BIRTH <b>NEW YORK, N.Y.</b>	
5. DATE OF DEATH <b>1961-11-11</b>		6. PLACE OF DEATH <b>NEW YORK, N.Y.</b>	
7. TIME OF DEATH <b>11:00 AM</b>		8. CAUSE OF DEATH <b>HEART DISEASE</b>	
9. MANNER OF DEATH <b>NATURAL</b>		10. MEDICAL HISTORY <b>None</b>	
11. SIGNATURE OF DECEASED <b>J. J. Martin</b>		12. SIGNATURE OF WITNESS <b>J. J. Martin</b>	
13. SIGNATURE OF PHYSICIAN <b>J. J. Martin</b>		14. SIGNATURE OF CORONER <b>J. J. Martin</b>	
15. SIGNATURE OF JURY <b>J. J. Martin</b>		16. SIGNATURE OF JURY <b>J. J. Martin</b>	
17. SIGNATURE OF JURY <b>J. J. Martin</b>		18. SIGNATURE OF JURY <b>J. J. Martin</b>	
19. SIGNATURE OF JURY <b>J. J. Martin</b>		20. SIGNATURE OF JURY <b>J. J. Martin</b>	
21. SIGNATURE OF JURY <b>J. J. Martin</b>		22. SIGNATURE OF JURY <b>J. J. Martin</b>	
23. SIGNATURE OF JURY <b>J. J. Martin</b>		24. SIGNATURE OF JURY <b>J. J. Martin</b>	
25. SIGNATURE OF JURY <b>J. J. Martin</b>		26. SIGNATURE OF JURY <b>J. J. Martin</b>	
27. SIGNATURE OF JURY <b>J. J. Martin</b>		28. SIGNATURE OF JURY <b>J. J. Martin</b>	
29. SIGNATURE OF JURY <b>J. J. Martin</b>		30. SIGNATURE OF JURY <b>J. J. Martin</b>	
31. SIGNATURE OF JURY <b>J. J. Martin</b>		32. SIGNATURE OF JURY <b>J. J. Martin</b>	
33. SIGNATURE OF JURY <b>J. J. Martin</b>		34. SIGNATURE OF JURY <b>J. J. Martin</b>	
35. SIGNATURE OF JURY <b>J. J. Martin</b>		36. SIGNATURE OF JURY <b>J. J. Martin</b>	
37. SIGNATURE OF JURY <b>J. J. Martin</b>		38. SIGNATURE OF JURY <b>J. J. Martin</b>	
39. SIGNATURE OF JURY <b>J. J. Martin</b>		40. SIGNATURE OF JURY <b>J. J. Martin</b>	
41. SIGNATURE OF JURY <b>J. J. Martin</b>		42. SIGNATURE OF JURY <b>J. J. Martin</b>	
43. SIGNATURE OF JURY <b>J. J. Martin</b>		44. SIGNATURE OF JURY <b>J. J. Martin</b>	
45. SIGNATURE OF JURY <b>J. J. Martin</b>		46. SIGNATURE OF JURY <b>J. J. Martin</b>	
47. SIGNATURE OF JURY <b>J. J. Martin</b>		48. SIGNATURE OF JURY <b>J. J. Martin</b>	
49. SIGNATURE OF JURY <b>J. J. Martin</b>		50. SIGNATURE OF JURY <b>J. J. Martin</b>	
51. SIGNATURE OF JURY <b>J. J. Martin</b>		52. SIGNATURE OF JURY <b>J. J. Martin</b>	
53. SIGNATURE OF JURY <b>J. J. Martin</b>		54. SIGNATURE OF JURY <b>J. J. Martin</b>	
55. SIGNATURE OF JURY <b>J. J. Martin</b>		56. SIGNATURE OF JURY <b>J. J. Martin</b>	
57. SIGNATURE OF JURY <b>J. J. Martin</b>		58. SIGNATURE OF JURY <b>J. J. Martin</b>	
59. SIGNATURE OF JURY <b>J. J. Martin</b>		60. SIGNATURE OF JURY <b>J. J. Martin</b>	
61. SIGNATURE OF JURY <b>J. J. Martin</b>		62. SIGNATURE OF JURY <b>J. J. Martin</b>	
63. SIGNATURE OF JURY <b>J. J. Martin</b>		64. SIGNATURE OF JURY <b>J. J. Martin</b>	
65. SIGNATURE OF JURY <b>J. J. Martin</b>		66. SIGNATURE OF JURY <b>J. J. Martin</b>	
67. SIGNATURE OF JURY <b>J. J. Martin</b>		68. SIGNATURE OF JURY <b>J. J. Martin</b>	
69. SIGNATURE OF JURY <b>J. J. Martin</b>		70. SIGNATURE OF JURY <b>J. J. Martin</b>	
71. SIGNATURE OF JURY <b>J. J. Martin</b>		72. SIGNATURE OF JURY <b>J. J. Martin</b>	
73. SIGNATURE OF JURY <b>J. J. Martin</b>		74. SIGNATURE OF JURY <b>J. J. Martin</b>	
75. SIGNATURE OF JURY <b>J. J. Martin</b>		76. SIGNATURE OF JURY <b>J. J. Martin</b>	
77. SIGNATURE OF JURY <b>J. J. Martin</b>		78. SIGNATURE OF JURY <b>J. J. Martin</b>	
79. SIGNATURE OF JURY <b>J. J. Martin</b>		80. SIGNATURE OF JURY <b>J. J. Martin</b>	
81. SIGNATURE OF JURY <b>J. J. Martin</b>		82. SIGNATURE OF JURY <b>J. J. Martin</b>	
83. SIGNATURE OF JURY <b>J. J. Martin</b>		84. SIGNATURE OF JURY <b>J. J. Martin</b>	
85. SIGNATURE OF JURY <b>J. J. Martin</b>		86. SIGNATURE OF JURY <b>J. J. Martin</b>	
87. SIGNATURE OF JURY <b>J. J. Martin</b>		88. SIGNATURE OF JURY <b>J. J. Martin</b>	
89. SIGNATURE OF JURY <b>J. J. Martin</b>		90. SIGNATURE OF JURY <b>J. J. Martin</b>	
91. SIGNATURE OF JURY <b>J. J. Martin</b>		92. SIGNATURE OF JURY <b>J. J. Martin</b>	
93. SIGNATURE OF JURY <b>J. J. Martin</b>		94. SIGNATURE OF JURY <b>J. J. Martin</b>	
95. SIGNATURE OF JURY <b>J. J. Martin</b>		96. SIGNATURE OF JURY <b>J. J. Martin</b>	
97. SIGNATURE OF JURY <b>J. J. Martin</b>		98. SIGNATURE OF JURY <b>J. J. Martin</b>	
99. SIGNATURE OF JURY <b>J. J. Martin</b>		100. SIGNATURE OF JURY <b>J. J. Martin</b>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7689

CERTIFICATE OF DEATH

07670

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>2yr2mth9dys</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> <b>3Y01-4</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				d. STREET ADDRESS <b>5506 Rubin Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>Aaron</b> Last <b>Rettman</b>				4. DATE OF DEATH Month <b>July</b> Day <b>12</b> Year <b>19 59</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>1876</b>		9. AGE (In years last birthday) <b>82</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>cooperage business</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retail</b>		11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>Russia</b> ✓	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>Unknown</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Mid-thigh amputation of left extremity on 7-8-59 due to arteriosclerotic</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>gangrene</b>					
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 3</b> , 19 <b>57</b> , to <b>July 12</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>July 12</b> , 19 <b>59</b> , and that death occurred at <b>11:45 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Stella Wachslar</b>				ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>7-13-59</b>			
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 14 / 59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Shalom Zion</b>		22d. LOCATION (City, town, or county) (State) <b>Wheatdale, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Sol Gerson</b>				ADDRESS <b>1124-26 W. North Ave</b>		24a. REC'D BY REGISTRAR <b>SUL 16 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Charles S. House</b>			

200

7690

# CERTIFICATE OF DEATH

Reg. Dist. No.

07671

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town.) <u>Parkville</u>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Parkville</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3219 Hiss Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Mr. William J.</u> First, Middle Last <u>Reuschling</u>				4. DATE OF DEATH Month <u>July</u> Day <u>14</u> Year <u>19 59</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
8. DATE OF BIRTH <u>3-19-1901</u>		9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gas &amp; Elec. Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>						
13. FATHER'S NAME <u>William J. Reuschling</u>				14. MOTHER'S MAIDEN NAME <u>Clara Tillman</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Informant</u>		Address <u>Mrs Clara Reuschling same</u>		
18. CAUSE OF DEATH [Enter only one cause pertaining to (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cholangiocarcinoma</u> <u>155.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 month</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town)		(County)		(State)		
21. I certify that I attended the deceased from <u>January 17, 1950</u> , to <u>July 14, 1959</u> ; that I last saw the deceased alive on <u>July 14, 1959</u> , and that death occurred at <u>7:15 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6217 Harford Rd Baltimore</u> DATE SIGNED <u>7/14/59</u> ACTUAL SIGNATURE <u>E. J. Alessi MD.</u> M.D. PHYSICIAN'S NAME (Type)						
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-17-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cem.</u>		
22d. LOCATION (City, town, or county) <u>Baltimore, Md.</u>		(State)				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Rd.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 16 '59</u>		
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>						





may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7691

CERTIFICATE OF DEATH

07672

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>New York</b> b. COUNTY <b>Queens Borough</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jackson Heights 69X-3</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>311 Ivy Church Road</b>				d. STREET ADDRESS <b>3446 91st Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>RUBINO</b> Last				4. DATE OF DEATH Month <b>July</b> Day <b>11</b> Year <b>1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 1, 1875</b>	
9. AGE (In years less birthday) yrs. <b>83</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Michael Pietro</b>				14. MOTHER'S MAIDEN NAME <b>Vincenza Pietro</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT Address <b>Anthony Rubino, 311 Ivy Church Rd., Towson, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive C.V. disease</b> DUE TO (c) <b>Arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis</b>							
INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 1959</b> to <b>July 1959</b> that I last saw the deceased alive on <b>July 10th 1959</b> , and that death occurred at <b>12:00 AM</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Louis J. Pratt Jr. M.D.</b>				ADDRESS (Street, city or town, state) <b>8402 Seewright Rd - 4</b> DATE SIGNED <b>7/11/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 15, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. John's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Queens, New York</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns' Sons, Towson, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 17 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kneass</b>	

2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 2681, 2682, 26

CEMO

DOI 10.1002/jbm.b

V.

2291, 11, 1972.

6

517

2.7.2008

250

6120

42003015

containing feeds:

2007.

9

Anthony Sabino, 21 Ivy Church St., Towson, Md.

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
M  
X  
I  
0  
M  
Y  
S  
A  
R  
D  
I  
A  
N  
L  
A  
N  
D  
S  
D  
O  
W  
N  
E  
B  
A  
U  
G  
H  
E  
R  
R  
U  
C  
K  
E  
R  
B  
A  
L  
T  
I  
M  
O  
R  
E  
B  
I  
G  
L  
E  
Y  
A  
V  
E  
N  
U  
E  
J  
U  
L  
Y  
1  
3  
O  
C  
T  
O  
B  
E  
R  
4  
1  
8  
9  
4  
A  
L  
I  
C  
E  
E  
L  
L  
I  
O  
T  
T  
W  
I  
L  
L  
I  
A  
M  
R  
J  
O  
H  
N  
S  
O  
N  
H  
O  
W  
A  
R  
D  
H  
H  
U  
B  
B  
A  
R  
D  
G  
L  
E  
N  
H  
A  
V  
E  
N  
C  
E  
M  
E  
T  
E  
R  
Y  
A  
A  
C  
O  
M  
A  
R  
Y  
L  
A  
N  
D

7556

## CERTIFICATE OF DEATH

Reg. Dist. No.

07673

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lansdowne</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>57 Baltimore (Lansdowne)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>358 Bigley Avenue</b>		d. STREET ADDRESS <b>358 Bigley Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Emily Baugher Rucker</b>		4. DATE OF DEATH Month <b>July</b> Day <b>13</b> Year <b>19 59</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 4, 1894</b>
9. AGE (In years lost birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William R. Baugher</b>		14. MOTHER'S MAIDEN NAME <b>Ida Lewis</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. Alice Elliott</b>		Address <b>358 Bigley Avenue #27</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized sarcomatosis, metastatic, to</b> <b>174X</b> DUE TO <b>brain and lungs, with right hemiplegia,</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>due to sarcom of uterus,</b> DUE TO (c) <b>short time</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 9, 1959</b> to <b>July 12, 1959</b> that I last saw the deceased alive on <b>July 12, 1959</b> and that death occurred at <b>6:00</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>William R. Johnson</b> <b>403 Medial Arts Bldg. Balto. 1, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/15/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>A. A. Co. Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 15 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

Burial		Howard H. Hulsford 4107 Wilkens Ave.	
Funeral		7/25/59 Glen Haven Cemetery A. A. Co. Maryland	
Deceased		William R. Johnson 403 Medical Arts Bldg. Balto. 1, Md.	
Cause of Death		Generalized sarcomatous, metastatic, to brain and lungs, with right hemiplegia, due to sarcoma of uterus	
Duration of Illness		Short time	
Place of Death		Home	
Name of Deceased		Alice Wilcox 358 Bixley Avenue 27	
Name of Informant		Mrs. Ida Lewis	
Relationship		Housewife	
Sex		Female	
Race		White	
Age		Oct. 4, 1894 64	
Date of Death		July 13, 1959	
Place of Birth		358 Bixley Avenue	
City		Baltimore	
State		Maryland	
County		Baltimore	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7692

## CERTIFICATE OF DEATH

Reg. Dist. No.

07674

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>1yrlmth22dys</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Lillian</b> Middle <b>Agnes</b> Last <b>Sager</b>				4. DATE OF DEATH Month <b>July</b> Day <b>15</b> Year <b>1959</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 28, 1886</b>	9. AGE (In years and birth day) <b>73 yrs.</b>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			13. FATHER'S NAME <b>Franklin Pilling</b>				
14. MOTHER'S MAIDEN NAME <b>Elizabeth Beans</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>				
16. SOCIAL SECURITY NO. <b>Unknown</b>			17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 5, 1959</b> , to <b>July 15, 1959</b> , that I last saw the deceased alive on <b>July 15, 1959</b> , and that death occurred at <b>12:30 a.m.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Stella Wachslar</b> M.D.				ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b>			
DATE SIGNED <b>7-15-59</b>							
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-17-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck</b>				ADDRESS <b>5305 Harford Rd.</b>			
24a. REC'D BY REGISTRAR <b>Jul 16 1959</b>				24b. REGISTRAR'S SIGNATURE <b>Jul 16 1959</b>			

CERTIFICATE OF DEATH

5333

WILLIAM B. BOND  
JANUARY 1900

Name of deceased		Age		Sex		Race		Color		Religion		Marital status		Occupation		Cause of death		Place of death		Date of death		Time of death		Signature of physician		Signature of registrar		Signature of witness	
WILLIAM B. BOND		45		Male		White		White		Roman Catholic		Married		Carpenter		Heart disease		Home		January 1, 1900		10:00 AM		J. B. Bond		J. B. Bond		J. B. Bond	



7693

## CERTIFICATE OF DEATH

07675

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>52 Catonsville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>115 Fairfield Dr.</b>				d. STREET ADDRESS <b>115 Fairfield Dr.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>Lydia Mary Sapp</b>				4. DATE OF DEATH Month Day Year <b>July 18, 19 59</b>			
5. SEX <b>F.</b>		6. COLOR OR RACE <b>W.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 14, 1873</b>	
9. AGE (In years last birthday) <b>86</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H.W.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>O.H.</b>		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Christian Heisler</b>				14. MOTHER'S MAIDEN NAME <b>Eva -----</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>Mr. Francis H. Sapp, 115 Fairfield Dr.</b>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic C.V.D.</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <b>years</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>July 14, 19 59</b> to <b>July 18, 19 59</b> that I last saw the deceased alive on <b>July 14, 19 59</b> , and that death occurred at <b>5:25</b> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>3325 Frederick Ave Balto Md</b>				DATE SIGNED <b>July 21 '59</b>			
ACTUAL SIGNATURE <b>J. C. Pound</b>				M.D. <b>3325 Frederick Ave Balto Md</b>			
PHYSICIAN'S NAME (Type) <b>J. C. Pound</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/21/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke Funeral Dir. 4101 Edmondson Ave.</b>				ADDRESS <b>4101 Edmondson Ave.</b>		24a. REC'D BY REGISTRAR <b>DATE JUL 21 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles S. K...</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corpse papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

847

05/14/2015

• 20 000 000 000 000

100

434

04

9761, 25 091001

•

10

• • •

• • •

Chlorine Chloride

252

...to the ... ..

11-11-1964

• • •

TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7694

## CERTIFICATE OF DEATH

07676

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockdale Balto. 7, Md.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Balto. 7.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3616 Langrehr Road, Balto. 7, Md.</b>				e. STREET ADDRESS <b>3616 Langrehr Road, Balto. 7, Md.</b>		e. IS RESIDENCE ON A FARM? <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Audrey</b> Middle <b>Christinia</b> Last <b>Schmauch</b>				4. DATE OF DEATH Month <b>July</b> Day <b>12</b> Year <b>19 59</b>			
5. SEX <b>F.</b>		6. COLOR OR RACE <b>W.</b>		7. MARRIED <input type="checkbox"/> <del>NEVER MARRIED</del>		8. DATE OF BIRTH <b>August 12, 1915</b>	
9. AGE (In years last birthday) yrs. <b>43</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Life Ins.</b>		11. BIRTHPLACE (State or foreign country) <b>Balto.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Philip F. Airey</b>			
14. MOTHER'S MAIDEN NAME <b>Catherine E. Brown</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			
16. SOCIAL SECURITY NO. <b>213-03-5712</b>				17. INFORMANT <b>Mr. Adam A. Schmauch</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>metastatic Carcinoma of Rectum.</b> DUE TO <b>154X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs.</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>July 13, 1959</b> , to <b>July 13, 1959</b> , that I last saw the deceased alive on <b>July 13, 1959</b> , and that death occurred at <b>12:45 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Morton J. Ellin</b>				DATE SIGNED <b>7/15/59</b>			
PHYSICIAN'S NAME (Type) <b>Morton J. Ellin</b>				ADDRESS (Street, city or town, state) <b>8627 Liberty Rd. Randallstown, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/15/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Loring Byers</b>				ADDRESS <b>8728 Liberty Road</b>		24a. REC'D BY REGISTRAR <b>DATE JUL 21 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kraus</b>							

CERTIFICATE OF DEATH

Salmon

Salmon

Salmon

Salmon

Salmon

Salmon

Salmon

Salmon

Salmon

Salmon

Salmon

Salmon

Salmon

Salmon

Salmon

Salmon

Salmon

Salmon

Salmon

Salmon

Salmon

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7695

Item 12 Film G244 7/9/59 cap

CERTIFICATE OF DEATH

Reg. Dist. No. 07677

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>3 Vol-4</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN 1b <u>3 YEARS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Caton Ridge Nursing Home</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>2734 Hayford Ave Balto 18, md</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <u>329 Harlem Lane Catonsville 28</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Anna Katherine Schmidt</u>		4. DATE OF DEATH Month Day Year <u>July 1 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 20, 1866</u>
9. AGE (In years last birthday) yrs. <u>93</u>		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>J. HENRY KABERNAGEL</u>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>1805 FREDRICK ROAD</u> Address <u>CAPT. ALFRED W. KABERNAGEL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Right lobar pneumonia</u> DUE TO <u>490 X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Spending Oxygen unknown</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cardiac failure Left</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>for</u> <u>1919</u> to <u>7/1</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6/30</u> , 19 <u>59</u> , and that death occurred at <u>6:20 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Cliff Ratliff, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>4605 EDMONDSON AVE</u> DATE SIGNED <u>7/1/59</u>	
PHYSICIAN'S NAME (Type) <u>CLIFF RATLIFF, JR.</u>		<u>BALTIMORE 29, md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>7/3/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>LOUDON PARK CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HENRY SANDER &amp; SONS INC. BALTO. MD.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>JUL 6 '59</u> DATE	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hinkle</u>

Sanders Funeral Parlor Broadway & North Ave

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		M		65		JAN 15 1880		BALTIMORE, MD	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
1234 E. BALTIMORE ST.		CARPENTER		HEART DISEASE		NATURAL		HOME	
DATE OF DEATH		TIME OF DEATH		HOURS OF DEATH		MINUTES OF DEATH		SECONDS OF DEATH	
JAN 25 1945		10:30 AM		10		30		00	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERK	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN 25 1945		JAN 25 1945		JAN 25 1945		JAN 25 1945		JAN 25 1945	



7696

CERTIFICATE OF DEATH

Reg. Dist. No. 07678

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Balto.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pikesville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pikesville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>3222 Smith Avenue</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Lucille Anne Schuman</i>		4. DATE OF DEATH <i>July 21 1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov 11, 1914</i>
9. AGE (In years last birthday) <i>44</i> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	11. BIRTHPLACE (State or foreign country) <i>Brooklyn, N. Y.</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Late Charles Gararelli</i>	
14. MOTHER'S MAIDEN NAME <i>Anna</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		INFORMANT <i>M. J. Harold Schuman - 3222 Smith Ave</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Coronary occlusion</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Rheumatic Cardiovascular disease</i>			INTERVAL BETWEEN ONSET AND DEATH <i>5 min</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>none</i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <i>Jan 1954</i> to <i>7/21 1959</i> that I last saw the deceased alive on <i>7/20 1959</i> and that death occurred at <i>9 P.M.</i> from the causes and on the date stated above.	
ACTUAL SIGNATURE <i>D. Maurice Fieldman</i> M.D.		ADDRESS (Street, city or town, state) <i>2 E Read St.</i> DATE SIGNED <i>7/22/59</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>July 23/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Chesapeake Amuro</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Sol Lewin</i> ADDRESS <i>1124-26 W. North Ave</i>		24a. REC'D BY REGISTRAR DATE <i>JUL 24 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kenna</i>

1903



CERTIFICATE OF DEATH

1903

1

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7697 Item 8 Film G245 7-29-59 et  
CERTIFICATE OF DEATH

Reg. Dist. No. 07679

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kenwood Park</u>		c. LENGTH OF STAY IN 1b <u>21 yrs</u> x <u>Kenwood Park Fullerton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5231 Trumps Mill Rd.</u>		d. STREET ADDRESS <u>5231 Trumps Mill Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>Robert</u> Last <u>Schuster</u>		4. DATE OF DEATH Month <u>July</u> Day <u>20</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 7 1881</u>
9. AGE (In years last birthday) yrs. <u>78</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Builder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FREDERICK Schuster</u>		14. MOTHER'S MAIDEN NAME <u>GESEINE BORCHERS.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Anna B. Schuster</u>		Address <u>5231 Trumps Mill Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prostatic Cancer</u> <u>177X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>sev. yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anemia, secondary to endogenous malnutrition.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Spring</u> 19 <u>57</u> , to <u>7-20</u> 19 <u>59</u> , that I last saw the deceased alive on <u>3pm 7-22</u> 19 <u>59</u> , and that death occurred at <u>4:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John C. Hyle</u>		DATE SIGNED <u>7-21-59</u>	
PHYSICIAN'S NAME (Type) <u>JOHN C. Hyle</u>		ADDRESS (Street, city or town, state) <u>7527 Belair Rd Balto Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>JULY 23 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>LORRAINE PARK CEM</u>	22d. LOCATION (City, town, or county) (State) <u>WOODLAWN MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Duffel Bros 7110 Belair Road.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 23 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinas</u>			

CERTIFICATE OF DEATH

STATE OF NEW YORK

1927

1. Name of deceased		2. Sex		3. Age		4. Date of death		5. Place of death	
6. Cause of death		7. Duration of illness		8. Name of physician		9. Name of attending nurse		10. Name of undertaker	
11. Name of informant		12. Signature of informant		13. Signature of physician		14. Signature of attending nurse		15. Signature of undertaker	
16. Name of registrar		17. Signature of registrar		18. Signature of health officer		19. Signature of coroner		20. Signature of justice of the peace	
21. Name of funeral home		22. Signature of funeral home		23. Signature of cemetery		24. Signature of burial place		25. Signature of interment	
26. Name of cemetery		27. Signature of cemetery		28. Signature of burial place		29. Signature of interment		30. Signature of burial place	
31. Name of burial place		32. Signature of burial place		33. Signature of interment		34. Signature of burial place		35. Signature of interment	
36. Name of interment		37. Signature of interment		38. Signature of burial place		39. Signature of interment		40. Signature of burial place	
41. Name of burial place		42. Signature of burial place		43. Signature of interment		44. Signature of burial place		45. Signature of interment	
46. Name of interment		47. Signature of interment		48. Signature of burial place		49. Signature of interment		50. Signature of burial place	
51. Name of burial place		52. Signature of burial place		53. Signature of interment		54. Signature of burial place		55. Signature of interment	
56. Name of interment		57. Signature of interment		58. Signature of burial place		59. Signature of interment		60. Signature of burial place	
61. Name of burial place		62. Signature of burial place		63. Signature of interment		64. Signature of burial place		65. Signature of interment	
66. Name of interment		67. Signature of interment		68. Signature of burial place		69. Signature of interment		70. Signature of burial place	
71. Name of burial place		72. Signature of burial place		73. Signature of interment		74. Signature of burial place		75. Signature of interment	
76. Name of interment		77. Signature of interment		78. Signature of burial place		79. Signature of interment		80. Signature of burial place	
81. Name of burial place		82. Signature of burial place		83. Signature of interment		84. Signature of burial place		85. Signature of interment	
86. Name of interment		87. Signature of interment		88. Signature of burial place		89. Signature of interment		90. Signature of burial place	
91. Name of burial place		92. Signature of burial place		93. Signature of interment		94. Signature of burial place		95. Signature of interment	
96. Name of interment		97. Signature of interment		98. Signature of burial place		99. Signature of interment		100. Signature of burial place	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7698

## CERTIFICATE OF DEATH

07680

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>BALTO. 13</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural: Towson</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Budwood Sanatorium Towson 4, Maryland</b>		d. STREET ADDRESS <b>3517 Pelham Avenue</b>	
3. NAME OF DECEASED a. (Type or print) First <b>Kela</b> Middle <b>MARY</b> Last <b>Scilipote</b>		4. DATE OF DEATH Month <b>July</b> Day <b>9</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-18-14</b>
9. AGE (In years last birthday) <b>44</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>4</b> Days <b>1</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Boston, Pa</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Smith</b>		14. MOTHER'S MAIDEN NAME <b>Hazel Derringer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Personal History</b>		Address <b>Hospital Records, Eudwood Sanatorium</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b><del>STROKE</del> Pulmonary Edema</b> INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b>			
DOE TO <b>Myocardial Hypertrophy &amp; 5 yrs</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
DOE TO <b>Decompensation</b>			
(c) <b>Chronic Pulmonary Fibrosis, Tuberculosis 10 yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9/25</b> 19 <b>59</b> to <b>7/9</b> 19 <b>59</b> , that I last saw the deceased alive on <b>7/9</b> 19 <b>59</b> , and that death occurred at <b>1:25 PM</b> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <b>Eudwood Sanatorium, Towson 4, Md.</b>		DATE SIGNED	
ACTUAL SIGNATURE <b>Milton B. Kress</b>		M.D.	
PHYSICIAN'S NAME (Type) <b>Milton B. Kress, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7/13/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>PARKWOOD Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>LEONARD J Ruck</b>		ADDRESS <b>5305 HARFORD RD</b>	
24a. REC'D BY REGISTRAR <b>JUL 13 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kross</b>	

CERTIFICATE OF DEATH

1911-12

MA

2212 1610000000

22

9

101

MAE 2211000

MAE

1010

11-18-11

1010 1010

1010 1010

1010 1010

1010 1010

1010

1010

1010 1010

1010 1010

1



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7699

## CERTIFICATE OF DEATH

Reg. Dist. No. 07681

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glyndon</b>		c. LENGTH OF STAY IN 1b <b>X Glyndon</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>19 Butler Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>W.</b> Last <b>Seabold</b>		4. DATE OF DEATH Month <b>July</b> Day <b>5</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 1, 1878</b>
9. AGE (In years last birthday) yrs. <b>81</b>		10. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Asst. Chief clerk at B&amp;O R.R.</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore City</b>	
12. BIRTHPLACE (State or foreign country) <b>Baltimore City</b>		13. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
14. FATHER'S NAME <b>Charles A. Seabold</b>		15. MOTHER'S MAIDEN NAME <b>Minnie F. Flaggs</b>	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		17. SOCIAL SECURITY NO. <b>705-12-1490</b>	
18. INFORMANT <b>Dr. William Seabold</b>		Address <b>Glyndon, Md.</b>	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema and uremia</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) <b>Arteriosclerotic heart disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertrophy of prostate gland</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 12</b> , 19 <b>41</b> to <b>7-4-59</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>July 4</b> , 19 <b>59</b> , and that death occurred at <b>8 A.</b> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>23 Hanover Road</b> DATE SIGNED ACTUAL SIGNATURE <b>S. Walter Landau</b> M.D. PHYSICIAN'S NAME (Type) <b>S. Walter Landau, M.D.</b> <b>Reisterstown, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 8, 59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Pikesville Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.F.Eline &amp; Sons</b>		ADDRESS <b>Reisterstown, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>JUL 9 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Haines</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7700

## CERTIFICATE OF DEATH

Reg. Dist. No.

07682

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>✓</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>9mth8dys</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>				d. STREET ADDRESS <b>2918 Presstman Street #16</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Sarah</b> Middle <b>XX</b> R. <b>Serio</b> Last <b>Serio</b>				4. DATE OF DEATH Month <b>July</b> Day <b>31</b> Year <b>19 59</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. <del>MARRIED</del> <input checked="" type="checkbox"/> <del>NEVER MARRIED</del> <input checked="" type="checkbox"/> <del>WIDOWED</del> <input type="checkbox"/> <del>XXXXXX</del> <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>5, 1889</b> <b>Dec. 1889</b>	
9. AGE (In years last birthday) yrs. <b>69</b>		IF UNDER 1 YEAR Months <b>69</b> Days <b>69</b> Hours <b>69</b> Min. <b>69</b>		IF UNDER 24 HRS. Months <b>69</b> Days <b>69</b> Hours <b>69</b> Min. <b>69</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>Italy</b>				12. CITIZEN OF WHAT COUNTRY? <b>Italy</b> ✓			
13. FATHER'S NAME <b>Joseph Serio</b>				14. MOTHER'S MAIDEN NAME <b>Concetta Giglio</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <del>XXXXXX</del>				16. SOCIAL SECURITY NO. <b>None</b> <del>XXXXXXXX</del>			
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>260x</b> <b>Irreversible diabetic coma.</b> DUE TO <b>CVA. (Cerebral vascular accident).</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Interval between onset and death</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>19</b> Month, Day, Year				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Oct. 23, 1958</b> to <b>7/31/59</b> , that I last saw the deceased alive on <b>7/31/59</b> , and that death occurred at <b>11:30 PM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>7/31/59</b>							
ACTUAL SIGNATURE <b>Bruno Radauskas</b> M.D.				PHYSICIAN'S NAME (Type) <b>BRUNO RADAUSKAS</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>8/4/59</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>				22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm J. Lick...</b>				24a. REC'D BY REGISTRAR <b>AUG 3 59</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Howard</b>							

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7701

Item 2 Film 6246 7-31-59 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

07683

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>2 Years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville Baltimore 3V01-4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Paradise Nursing Home</b>				d. STREET ADDRESS <b>2708 Oswego Avenue Pardise Ave, Catonsville, Md.</b>		e. IS RESIDENCE ON A FARM? <b>NO</b>	
3. NAME OF DECEASED (Type or print) First <b>Nellie</b> Middle <b>A.</b> Last <b>Sheets</b>				4. DATE OF DEATH Month <b>July</b> Day <b>13</b> Year <b>1959</b>			
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED <input type="checkbox"/> <del>SEPARATED</del>	8. DATE OF BIRTH <b>July 12, 1873</b>		9. AGE (In years last birthday) yrs. <b>86</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>***** 213-10-1544</b>		17. INFORMANT <b>Mrs. Evelyn Anderson 2708 Oswego Ave, Balto. D</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Degenerative Heart Disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b> (c) <b>Chronic Brain Syndrome</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>1959 7/13/59</b>	
20f. (City or town) <b>Balto.</b>				20g. (County) <b>Md.</b>			
20h. (State) <b>Md.</b>				20i. (City or town) <b>Balto.</b>			
21. I certify that I attended the deceased from <b>Jan 19 1959</b> to <b>7/11/59</b> , that I last saw the deceased alive on <b>7/11/59</b> , and that death occurred at <b>1:55 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>W.E. Mc Grath M. D.</b>				ADDRESS (Street, city or town, state) <b>1303 Frederick Road</b>			
PHYSICIAN'S NAME (Type) <b>W.E. Mc Grath M. D.</b>				DATE SIGNED <b>7/14/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/15/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Loring Byers</b>				ADDRESS <b>8728 Liberty Road</b>		24a. REC'D BY REGISTRAR <b>DATE JUL 21 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Charles E. Howard</b>			

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13

## CERTIFICATE OF DEATH

1707

NAME OF DECEASED  
 SEX  
 AGE  
 DATE OF BIRTH

PLACE OF BIRTH  
 DATE OF DEATH  
 TIME OF DEATH

CAUSE OF DEATH  
 PLACE OF DEATH

DATE OF INTERMENT  
 PLACE OF INTERMENT

DATE OF BURIAL  
 PLACE OF BURIAL

DATE OF CREMATION  
 PLACE OF CREMATION

DATE OF EXHUMATION  
 PLACE OF EXHUMATION

DATE OF REINTERMENT  
 PLACE OF REINTERMENT

DATE OF REINTERMENT  
 PLACE OF REINTERMENT

DATE OF REINTERMENT  
 PLACE OF REINTERMENT

DATE OF REINTERMENT  
 PLACE OF REINTERMENT

DATE OF REINTERMENT  
 PLACE OF REINTERMENT

DATE OF REINTERMENT  
 PLACE OF REINTERMENT

DATE OF REINTERMENT  
 PLACE OF REINTERMENT

DATE OF REINTERMENT  
 PLACE OF REINTERMENT

DATE OF REINTERMENT  
 PLACE OF REINTERMENT

DATE OF REINTERMENT  
 PLACE OF REINTERMENT

DATE OF REINTERMENT  
 PLACE OF REINTERMENT

DATE OF REINTERMENT  
 PLACE OF REINTERMENT



7702

## CERTIFICATE OF DEATH

Reg. Dist. No.

07684

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1908 Kernan Drive</b>		d. STREET ADDRESS <b>1908 Kernan Drive</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Dora A. Shipley</b> First Middle Last		4. DATE OF DEATH <b>July 18</b> Month Day Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6 - 22 - 1884</b>
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John King</b>		14. MOTHER'S MAIDEN NAME <b>Kate Sarbacher</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>-----</b>	
17. INFORMANT <b>Edwin E. Shipley-1908 Kernan Drive</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatous</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of Stomach</b> DUE TO (c) <b>6 mths</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 18, 1959</b> to <b>July 18, 1959</b> that I last saw the deceased alive on <b>July 18, 1959</b> , and that death occurred at <b>11:15 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Danish Pelagosa</b> M.D. <b>3326 Ardenwick Ave</b> PHYSICIAN'S NAME (Type) <b>Balto 21 Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 21-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Western Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. B. Wipperf</b>		ADDRESS <b>1300 Rutaw Place</b>	
24a. REC'D BY REGISTRAR <b>JUL 21 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Knead</b>	

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY CLERK EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1  
M  
1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7703 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07685

1. PLACE OF DEATH a. COUNTY <b>Balto</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Balto</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Balto rural</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Balto rural</b>	
3. NAME OF DECEASED (Type or print) First <b>NANNIE</b> Middle <b>V.</b> Last <b>SIMMS</b>		4. DATE OF DEATH Month <b>July</b> Day <b>8</b> Year <b>19 59</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5 Oct 1879</b>
9. AGE (In years last birthday) <b>79</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Norris</b>		14. MOTHER'S MAIDEN NAME <b>Susie Kennard</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Helen Jenkins Winfield(niece) same</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>442X</b> DUE TO <b>Renal Degeneration</b> Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO <b>Atherosclerotic cardiavascular disease</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>unk</b> <b>unk</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Complete anorexia</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>John C. Hyle</b> EXAMINER'S NAME (Type) <b>John C Hyle MD</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <b>7-8-59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-13-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. Park</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Matthew A. Hensley</b> ADDRESS <b>578 W. Diddle St</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 15 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles E. Hensley</b>			

# MAINE STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

6-10-20

DATE

TIME

PLACE

John Smith

John Smith

200 Main Street, Portland, Me.

200 Main Street, Portland, Me.

1

2

3

4

5

6

200 Main Street

200 Main Street

200 Main Street

200 Main Street

John Smith

John Smith

John Smith (John Smith)

John Smith

John Smith

John Smith

John Smith

John Smith

John Smith

John Smith

John Smith

John Smith

7-10-20

John B. Smith

John B. Smith

John B. Smith

7-10-20

John B. Smith

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7704

Item 9 Film G244 7/10/59 cap

CERTIFICATE OF DEATH

Reg. Dist. No.

07386

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>CARROLL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ETTA</b> Middle <b>SINDLER</b> Last <b>SINDLER</b>		4. DATE OF DEATH Month <b>7</b> Day <b>3</b> Year <b>1959</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-23-97</b>
9. AGE (In years lost birthday) <b>61 60 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MARY LAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>FRANKLIN BOBLITZ</b>		14. MOTHER'S MAIDEN NAME <b>MARY ALVAN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-36-822</b>	
17. INFORMANT <b>Hospital Records, Mt. Wilson State Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF THE LUNG</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CARCINOMA OF THE KIDNEYS - LIVER, PANCREAS + LYMPH NODES</b> DUE TO (c) <b>-</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>LOR PULMONALE</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5-28</b> , 19 <b>59</b> , to <b>7-3-59</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>7-3</b> , 19 <b>59</b> , and that death occurred at <b>11:55 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William Newcomer</b> M.D.		ADDRESS (Street, city or town, state) <b>Mt. Wilson, Maryland</b>	
DATE SIGNED			
PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b>		<b>Superintendent</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>JULY-7-1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>GRAVE RUN</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE COUNTY, MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. COOK-TOWSON, INC. TOWSON 4MD</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>DATE 7 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Howard</b>	





7705

CERTIFICATE OF DEATH

Reg. Dist. No.

07687

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>BALTO</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WOODLAWN</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WOODLAWN</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>106 LOCUST DRIVE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>BERTHA ELIZ-GREFFEN-SKIPPER</b>		4. DATE OF DEATH <b>JULY 13 1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 25, 1900</b>
9. AGE (In years last birthday) <b>58</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry Greffen</b>		14. MOTHER'S MAIDEN NAME <b>Elma Ames</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Milton Warren Skipper</b>		Address <b>106 Locust Dr.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Crownary Thrombosis</b> <b>420.1</b> DUE TO <b>Cardio Vascular Disease &amp; Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardio Vascular Disease &amp; Hypertension</b> (c) <b>Hypertension</b>			INTERVAL BETWEEN ONSET AND DEATH <b>11/11/59</b> <b>1945</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>5/8</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>11/11</b> , 19 <b>59</b> , and that death occurred at <b>7:00 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Eliot W. Johnson</b>		ADDRESS (Street, city or town, state) <b>3432 Frederick Ave Baltimore 29. Md.</b>	
PHYSICIAN'S NAME (Type) <b>E. W. JOHNSON</b>		DATE SIGNED <b>7/12/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>July 16 - 1959</b>	<b>Lorraine Cem</b>	<b>Balto Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John F. Temple</b>		ADDRESS <b>5311 Edmondson Ave</b>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	
DATE <b>Jul 14 '59</b>			

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

07883

## CERTIFICATE OF DEATH

1902

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 45	
4. DATE OF DEATH Jan 15 1902		5. TIME OF DEATH 10:30 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Heart Disease		8. MANNER OF DEATH Natural		9. PLACE OF BIRTH England	
10. OCCUPATION Carpenter		11. MARITAL STATUS Married		12. EDUCATION None	
13. RELIGION Anglican		14. COLOR White		15. HEIGHT 5' 8"	
16. WEIGHT 160 lbs		17. BUILD Medium		18. COMPLEXION Fair	
19. EYES Blue		20. HAIR Brown		21. SKIN Fair	
22. TENDRILS None		23. TEETH None		24. NAILS None	
25. FINGERS None		26. TOES None		27. FEET None	
28. HANDS None		29. WRISTS None		30. ELBOWS None	
31. SHOULDERS None		32. NECK None		33. THROAT None	
34. CHEST None		35. BACK None		36. LIMBS None	
37. OTHER None		38. OTHER None		39. OTHER None	
40. OTHER None		41. OTHER None		42. OTHER None	
43. OTHER None		44. OTHER None		45. OTHER None	
46. OTHER None		47. OTHER None		48. OTHER None	
49. OTHER None		50. OTHER None		51. OTHER None	
52. OTHER None		53. OTHER None		54. OTHER None	
55. OTHER None		56. OTHER None		57. OTHER None	
58. OTHER None		59. OTHER None		60. OTHER None	
61. OTHER None		62. OTHER None		63. OTHER None	
64. OTHER None		65. OTHER None		66. OTHER None	
67. OTHER None		68. OTHER None		69. OTHER None	
70. OTHER None		71. OTHER None		72. OTHER None	
73. OTHER None		74. OTHER None		75. OTHER None	
76. OTHER None		77. OTHER None		78. OTHER None	
79. OTHER None		80. OTHER None		81. OTHER None	
82. OTHER None		83. OTHER None		84. OTHER None	
85. OTHER None		86. OTHER None		87. OTHER None	
88. OTHER None		89. OTHER None		90. OTHER None	
91. OTHER None		92. OTHER None		93. OTHER None	
94. OTHER None		95. OTHER None		96. OTHER None	
97. OTHER None		98. OTHER None		99. OTHER None	
100. OTHER None		101. OTHER None		102. OTHER None	

This certificate is to be filled out by the attending physician or the coroner, and is to be signed by the registrar of the district in which the death occurred.

7706

CERTIFICATE OF DEATH

Reg. Dist. No.

117588

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>		c. LENGTH OF STAY IN 1b <b>12 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5510 Windsor Mill Rd</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>John W. Slator</b>		4. DATE OF DEATH <b>July 24, 1959</b>	
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 5, 1881</b>
9. AGE (In years last birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Rancher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own</b>	
11. BIRTHPLACE (State or foreign country) <b>England</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Albert</b>		14. MOTHER'S MAIDEN NAME <b>Harriet</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address <b>Mr William Flohr, 5510 Windsor Mill Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 CONGESTIVE HEART FAILURE</b> DUE TO (b) <b>ARTERIOSCLEROTIC HEART</b> DUE TO (c) <b>DISEASE + COR PULMONALE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b> <b>3 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <b>CHRONIC ASTHMATIC BRONCHITIS + EMPHYSEMA</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>JUNE 14, 1957</b> to <b>JULY 17, 1959</b> that I lost saw the deceased alive on <b>JULY 17, 1959</b> , and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Carlton L. Sexton</b>		ADDRESS (Street, city or town, state) <b>July 24, 1959</b> DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>CARLTON L. SEXTON</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>Jul. 24/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Riverview Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Williston N.D.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke Funeral Dir. 4101 Edmondson Ave.</b>		24a. REC'D BY REGISTRAR <b>JUL 28 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

2075

πλάτος 100 cm

•

2

1361, 8-30A

•

100-441000

15

1997

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7707

## CERTIFICATE OF DEATH

07689

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville 52</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1009 Ingleside Avenue</b>				d. STREET ADDRESS <b>1009 Ingleside Avenue #28</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ELBERTA</b> Middle <b>MARIE</b> Last <b>SMITH</b>				4. DATE OF DEATH Month <b>July</b> Day <b>18</b> Year <b>19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 15, 1893</b>		9. AGE (In years lost birthday) yrs. <b>66</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John Oliver Brown</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Flynn</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Marie Reid-5480 Addington Road</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>420.1</b> DUE TO <b>Coronary Atherosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 years</b> <b>15 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma of Rt Breast &amp; Metastasis</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8/19</b> , 19 <b>55</b> , to <b>7-18</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>7-14</b> , 19 <b>59</b> , and that death occurred at <b>3 A.</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Leon Ashman</b>				ADDRESS (Street, city or town, state) <b>5907 Huguenot Club Ave Baltimore 7, Md</b>			
DATE SIGNED <b>7-18-59</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Entombment</b>		22b. DATE THEREOF <b>7/22/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Lorraine Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Woodlawn, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tichauer Home - Balto - 17, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 21 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton S. Kraus</b>	

# CERTIFICATE OF DEATH

Wm. J. T. ...  
 ...  
 ...



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

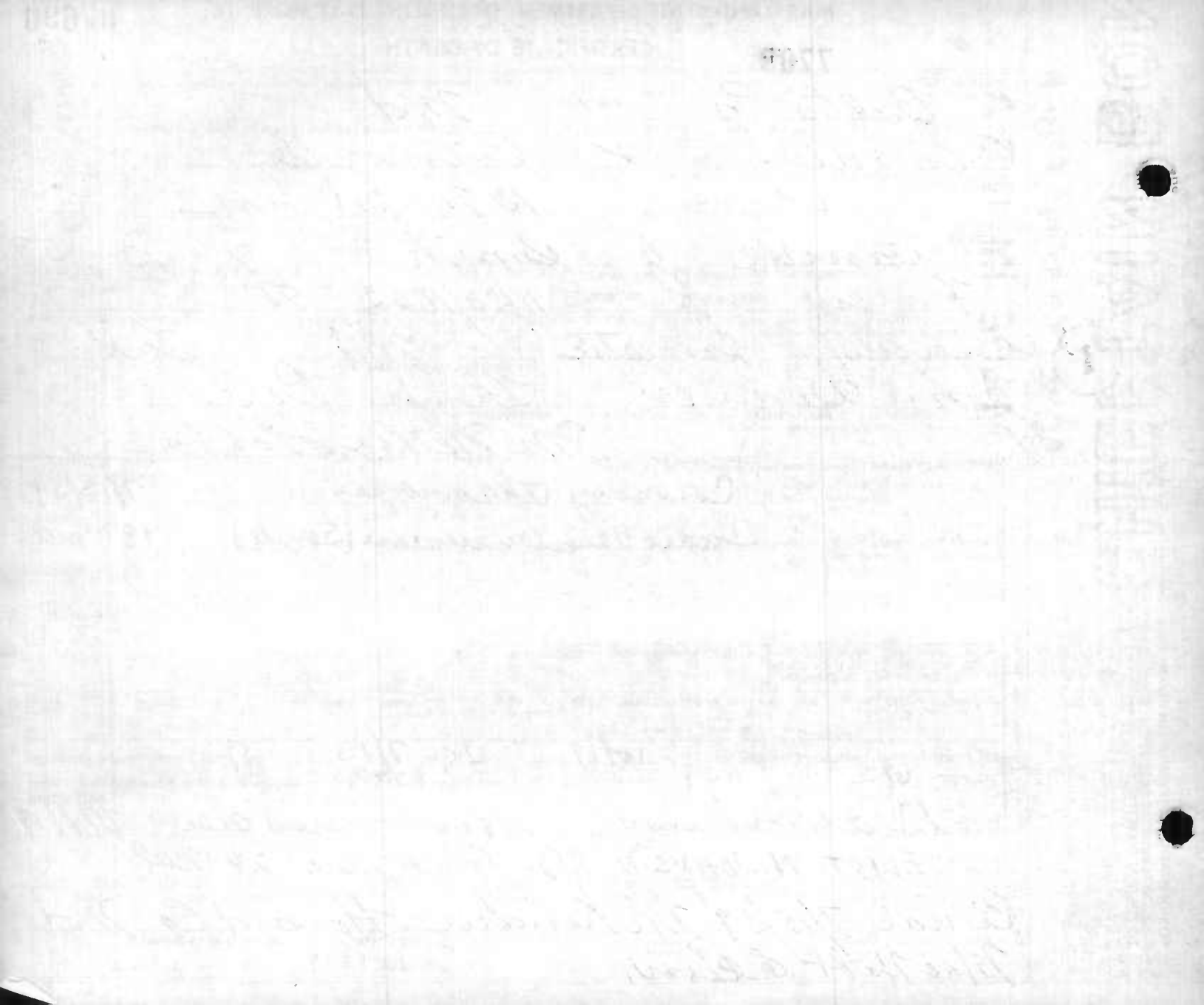
VS A15 (4)  
15M 9/58

7708

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville 52</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>At home</u>		d. STREET ADDRESS <u>10 Maple ave</u>	
3. NAME OF DECEASED (Type or print) <u>Fannie J Smith</u>		4. DATE OF DEATH Month <u>7</u> Day <u>13</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/20/1862</u>
9. AGE (In years last birthday) <u>96</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Banner</u>		14. MOTHER'S MAIDEN NAME <u>Thompe Pole</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Mrs Nettie Hobbs</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio Vascular Disease (Senile)</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>7/13/59</u> <u>18 Months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10/19</u> , 19 <u>48</u> to <u>7/13</u> , 19 <u>59</u> that I last saw the deceased alive on <u>7/2</u> , 19 <u>59</u> , and that death occurred at <u>6:00 AM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Eliot W. Johnson</u>		M.D. <u>3432 Francis Ave</u> ADDRESS (Street, city or town, state) DATE SIGNED <u>7/14/59</u>	
PHYSICIAN'S NAME (Type) <u>ELIOT W. JOHNSON MD. Baltimore 29 Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>7/15/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mc Kenzie</u>	22d. LOCATION (City, town, or county) (State) <u>Howard Co Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mac Matt &amp; Son</u>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <u>JUL 16 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7709

## CERTIFICATE OF DEATH

Reg. Dist. No.

07691

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Florida</u> b. COUNTY <u>Pasco</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>573 Edmundson Ave. (Ridgeway Manor N/H)</u>				d. STREET ADDRESS <u>#502 Warren Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Frederick Harvey Smith</u>				4. DATE OF DEATH Month Day Year <u>July 23 1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2 Sept. 1886</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours		IF UNDER 24 HRS. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician (ret.)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Civil Service</u>		11. BIRTHPLACE (State or foreign country) <u>Endfield, Connecticut</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Henry Smith</u>				14. MOTHER'S MAIDEN NAME <u>Margaret (Unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Mrs. Norma A. Smith</u>	
Address <u>520 Forest View Rd. Linthicum, Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Atrial C.V. Dis</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
MEDICAL CERTIFICATION							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>7/20</u> , 19 <u>59</u> , to <u>7/23</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>7/23</u> , 19 <u>59</u> , and that death occurred at <u>4:25</u> P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Theodore T. Nizirik M.D.</u>				ADDRESS (Street, city or town, state) <u>429 S. Charles St. Balto 3 Md.</u>			
PHYSICIAN'S NAME (Type) <u>Theo. T. Nizirik M.D.</u>				DATE SIGNED <u>7/24/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>27 July 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Landon Park</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. V. Singleton</u>				ADDRESS <u>6 Glen Burnie Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 27 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneale</u>			

CERTIFICATE OF DEATH

1900

DATE OF DEATH

MASSACHUSETTS

CITY OF BOSTON

NAME

AGE

SEX

DATE

TIME

PLACE

CAUSE

PLACE OF BIRTH

EDUCATION

RELIGION

PROFESSION

STATUS

DATE

TIME

PLACE

CAUSE

PLACE OF BIRTH

EDUCATION

RELIGION

PROFESSION

STATUS

DATE

TIME

PLACE

CAUSE

PLACE OF BIRTH

EDUCATION

RELIGION

PROFESSION

STATUS

DATE

TIME

PLACE

CAUSE

PLACE OF BIRTH

EDUCATION

RELIGION

PROFESSION

STATUS

DATE

TIME

PLACE

CAUSE

PLACE OF BIRTH

EDUCATION

RELIGION

PROFESSION

STATUS

DATE

TIME

PLACE

CAUSE

PLACE OF BIRTH

EDUCATION

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 18

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7710

## CERTIFICATE OF DEATH

Reg. Dist. No. 07692

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b> Md. </b> b. COUNTY <b> Balto. </b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b> Baltimore </b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b> 4714 Washington Blvd. </b>				d. STREET ADDRESS <b> 4714 Washington Blvd. </b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b> Glen Clifford Smith </b>				4. DATE OF DEATH Month Day Year <b> July 7 19 59 </b>							
5. SEX <b> male </b>		6. COLOR OR RACE <b> white </b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b> 9-27-08 </b>		9. AGE (In years last birthday) yrs. <b> 50 </b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b> Mech. Welder </b>				10b. KIND OF BUSINESS OR INDUSTRY <b> Empire Const. Co. Everett, Penn. </b>				11. BIRTHPLACE (State or foreign country) <b> U. S. A. </b>			
13. FATHER'S NAME <b> Harry Smith </b>				14. MOTHER'S MAIDEN NAME <b> Blanche Heaty </b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b> no </b>				16. SOCIAL SECURITY NO. <b> 170-12-3136 </b>				17. INFORMANT Address <b> Frances Eliz. Smith 4714 Washington Blvd </b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b> 162.1 Brochogenic Carcinoma </b> DUE TO <b> Central Metastasis </b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b> myocarditis (terminal) </b> DUE TO (c) <b> 5 mo 2 mo </b> INTERVAL BETWEEN ONSET AND DEATH											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b> Dec 15, 1939 </b> to <b> July 7, 1959 </b> , that I last saw the deceased alive on <b> July 7, 1959 </b> , and that death occurred at <b> 11:30 PM </b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b> 5609 Main St </b> DATE SIGNED <b> 7/8/59 </b>											
ACTUAL SIGNATURE <b> B B Brumbaugh </b> M.D.				PHYSICIAN'S NAME (Type) <b> B B Brumbaugh </b> <b> Elfridge 27 May </b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b> Burial </b>				22b. DATE THEREOF <b> 7/11/59 </b>		22c. NAME OF CEMETERY OR CREMATORY <b> Shreve Chapel Cem. </b>		22d. LOCATION (City, town, or county) (State) <b> Everett, Penn. </b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b> Howard H. Hubbard </b>						ADDRESS <b> 4107 Wilkens Ave. </b>		24a. REC'D BY REGISTRAR DATE <b> JUL 13 '59 </b>		24b. REGISTRAR'S SIGNATURE <b> Arthur S. Kraus </b>	

CERTIFICATE OF DEATH

Baltimore Md. Balno.

Baltimore

4114 Kensington Blvd. 4114 Washington Blvd.

John Clifford Smith July 7

male white 9-27-08 50

Meek, Welder Empire Corner, Co. Everett, Penn. U. S. A.

Larry Smith Blanche Healy

170-12-3138 Frances Elice Smith 4114 Washington Blvd

Burial 7/11/09 Shreve Chapel Cem. Everett, Penn.

Howard H. Hubbard 4107 Wilkens Ave.



## 7711 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riderwood</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riderwood</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1422 W. Joppa Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>OLIVE</b> Middle <b>SEIPP</b> Last <b>SMITH</b>		4. DATE OF DEATH Month <b>July</b> Day <b>19</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 4, 1891</b>
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>James A. Seipp</b>	
14. MOTHER'S MAIDEN NAME <b>Annie Mook</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>Family records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arterio-sclerosis &amp; hypertension</b> DUE TO <b>20 yrs</b> (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Sept 18, 1934</b> to <b>July 19, 1959</b> , that I last saw the deceased alive on <b>July 19, 1959</b> , and that death occurred at <b>5:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Robert R. Williams</b> M.D.		ADDRESS (Street, city or town, state) <b>1725 Rensselaer Rd. Pikesville 8 Md.</b>	
DATE SIGNED <b>July 22, 1959</b>		DATE SIGNED <b>July 22, 1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>July 22, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Prospect Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Towson, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns' Sons, Towson, Maryland</b>		24a. REC'D BY REGISTRAR <b>JUL 22 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Carlton S. Hume</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

CONFIDENTIAL

Belmont

Belmont

Belmont

Belmont

Belmont

James W. Thompson

James W. Thompson

July 10, 1950

REPLY

REPLY

REPLY

July 10, 1950

July 10, 1950

Belmont

Belmont

Belmont

James W. Thompson

James W. Thompson

Family records

Home

Home

July 10, 1950, Belmont, New York

John W. Thompson, Belmont, New York

7712

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b <b>3 wks.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Ridgeway Nursing Home</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>3401-4</b> d. STREET ADDRESS <b>300 Marydell Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>William A. Smith</b> First Middle Last		4. DATE OF DEATH <b>July 21, 1959</b> Month Day Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 25, 1888</b>
9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Barber</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Shop</b>	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Wallace Smith</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>216-10-2610</b>	
17. INFORMANT <b>A- Mabel E. Smith--300 Marydell Road</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO (b) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>1 MINUTE</b> <b>4 YEARS</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>JAN. 20</b> , 19 <b>56</b> , to <b>JULY 21</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>JULY 21</b> , 19 <b>59</b> , and that death occurred at <b>6:18 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John F. Schaefer</b> PHYSICIAN'S NAME (Type) <b>JOHN F. SCHAEFER</b>		ADDRESS (Street, city or town, state) <b>401 RANDOM ROAD BALTO. 29 MD.</b> DATE SIGNED <b>7/23/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	22b. DATE THEREOF <b>July 24/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Crematory</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. B. Shippert</b> ADDRESS <b>1300 Eutaw Place</b>		24a. REC'D BY REGISTRAR <b>DATE JUL 24 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Chas. E. Hanks</b>	

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7713

## CERTIFICATE OF DEATH

Reg. Dist. No.

07695

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE CO.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL or give nearest town) <b>PIKESVILLE</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>55 TOWSON</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>AUGSBURG HOME</b>				d. STREET ADDRESS <b>230 BURKE AVE.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>SOMN</b> Last <b>(SOHN)</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>14</b> Year <b>19 59</b>					
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 21, 1873</b>	9. AGE (In years last birthday) <b>86</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>FRANK HETTCHEN</b>				14. MOTHER'S MAIDEN NAME <b>KATE HEISER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		INFORMANT <b>CONRAD SOMN</b>		Address <b>TOWSON</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>260X - Diabetes mellitus</b> DUE TO (b) <b>Arterio-sclerotic Heart Disease</b> DUE TO (c) <b>Gangrene of Rt. Foot (2nd)</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized Arterio-sclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b> <b>5 yrs.</b> <b>2 months</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 1, 1959</b> , to <b>July 14, 1959</b> ; that I last saw the deceased alive on <b>July 12, 1959</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Earl L. Chambers</b>		M.D. <b>4108 Liberty St. C. Balto</b>		DATE SIGNED <b>7-17-59</b>			
PHYSICIAN'S NAME (Type) <b>DR. EARL L. CHAMBERS</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7/17/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>PARKWOOD CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>PARKVILLE MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns Sois</b>		ADDRESS <b>Towson, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 22 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles E. Kraus</b>	

2

3713

RECORDS OF CHAIR

0100

BALTIMORE CO.

MARYLAND

BALTIMORE

INVESTING

POWDER

WISCONSIN

WISCONSIN

MARY

DOUG

JULY

AT

22

STAIRS

MAY 21, 1973

86

BRIDGE

ONE WAY

MARYLAND

DEA

STAIRS

WATER

NO

HOME

CONCRETE

TOWNS

1

BURIAL

1/10/73

IN GOOD CONDITION

BRIDGE

MARYLAND



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film 6244 7-14-59 et

7714

CERTIFICATE OF DEATH

Reg. Dist. No.

07696

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>X Baltimore 12</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>At home</b>		d. STREET ADDRESS <b>508 Anneslie Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM CLEMENT SPRING</b>		4. DATE OF DEATH Month Day Year <b>7/2/59 July 3, 19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 1902</b>
9. AGE (In years last birthday) <b>56</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Publicity agent</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>self</b>	
11. BIRTHPLACE (State or foreign country) <b>New Hampshire</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Arthur W. Spring</b>		14. MOTHER'S MAIDEN NAME <b>Ann Finn</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Catheryne Spring</b>		Address <b>508 Anneslie Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cirrhosis of Liver</b> <b>581.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>5 wks.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 1957</b> , to <b>July 3, 1959</b> , that I last saw the deceased alive on <b>July 2, 1959</b> , and that death occurred at <b>4:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7501 York Rd</b> DATE SIGNED <b>7/5/59</b> ACTUAL SIGNATURE <b>Charles F. O'Donnell M.D.</b> PHYSICIAN'S NAME (Type) <b>Charles F. O'Donnell M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7/6/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Mem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Co.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WIEDEFELD &amp; SON</b>		ADDRESS <b>GREENMOUNT AVE &amp; 22ND</b>	
24a. REC'D BY REGISTRAR <b>JUL 8 59</b>		24b. REGISTRAR'S SIGNATURE <b>Civilian &amp; Trans</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7715

## CERTIFICATE OF DEATH

07697

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>44 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>SAMUEL L. STOLTZ</b>				4. DATE OF DEATH Month Day Year <b>July 6 1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 15, 1894</b>	9. AGE (In years last birthday) yrs. <b>65</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cemetery</b>		11. BIRTHPLACE (State or foreign country) <b>Lithuania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Israel Stoltz</b>				14. MOTHER'S MAIDEN NAME <b>Anna Freeman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>WW I 048-05-5854</b>		17. INFORMANT Address <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA, RIGHT MAXILLARY ANTRUM WITH METASTASIS</b> DUE TO 160.2 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 23</b> 19 <b>59</b> , to <b>July 6</b> 19 <b>59</b> , and that death occurred at <b>6:00 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>VAH, FORT HOWARD, MARYLAND 7/6/59</b>							
ACTUAL SIGNATURE <b>John W. Crawford</b>		PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D. VAH, FORT HOWARD, MARYLAND</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>7-6-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>B'Nai Israel Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hartford, Connecticut</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Blight, Inc. 6009 Harford Road Baltimore 14, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 9 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Carling L. Hines</b>	

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

Shipped to:

Weinstein Mortuary, 640 Farmington Ave., Hartford, Conn.

# CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>John Doe</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>10-15-1920</u></p>		<p>4. Place of birth: <u>St. Louis, Mo.</u></p>	
<p>5. Date of death: <u>12-15-1970</u></p>		<p>6. Place of death: <u>St. Louis, Mo.</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Manner of death: <u>Natural</u></p>	
<p>9. Signature of physician: <u>[Signature]</u></p>		<p>10. Signature of registrar: <u>[Signature]</u></p>	
<p>11. Name of hospital: <u>St. Louis Hospital</u></p>		<p>12. Name of funeral home: <u>St. Louis Funeral Home</u></p>	
<p>13. Name of next of kin: <u>John Doe</u></p>		<p>14. Name of informant: <u>John Doe</u></p>	
<p>15. Name of informant: <u>John Doe</u></p>		<p>16. Name of informant: <u>John Doe</u></p>	
<p>17. Name of informant: <u>John Doe</u></p>		<p>18. Name of informant: <u>John Doe</u></p>	
<p>19. Name of informant: <u>John Doe</u></p>		<p>20. Name of informant: <u>John Doe</u></p>	
<p>21. Name of informant: <u>John Doe</u></p>		<p>22. Name of informant: <u>John Doe</u></p>	
<p>23. Name of informant: <u>John Doe</u></p>		<p>24. Name of informant: <u>John Doe</u></p>	
<p>25. Name of informant: <u>John Doe</u></p>		<p>26. Name of informant: <u>John Doe</u></p>	
<p>27. Name of informant: <u>John Doe</u></p>		<p>28. Name of informant: <u>John Doe</u></p>	
<p>29. Name of informant: <u>John Doe</u></p>		<p>30. Name of informant: <u>John Doe</u></p>	
<p>31. Name of informant: <u>John Doe</u></p>		<p>32. Name of informant: <u>John Doe</u></p>	
<p>33. Name of informant: <u>John Doe</u></p>		<p>34. Name of informant: <u>John Doe</u></p>	
<p>35. Name of informant: <u>John Doe</u></p>		<p>36. Name of informant: <u>John Doe</u></p>	
<p>37. Name of informant: <u>John Doe</u></p>		<p>38. Name of informant: <u>John Doe</u></p>	
<p>39. Name of informant: <u>John Doe</u></p>		<p>40. Name of informant: <u>John Doe</u></p>	
<p>41. Name of informant: <u>John Doe</u></p>		<p>42. Name of informant: <u>John Doe</u></p>	
<p>43. Name of informant: <u>John Doe</u></p>		<p>44. Name of informant: <u>John Doe</u></p>	
<p>45. Name of informant: <u>John Doe</u></p>		<p>46. Name of informant: <u>John Doe</u></p>	
<p>47. Name of informant: <u>John Doe</u></p>		<p>48. Name of informant: <u>John Doe</u></p>	
<p>49. Name of informant: <u>John Doe</u></p>		<p>50. Name of informant: <u>John Doe</u></p>	
<p>51. Name of informant: <u>John Doe</u></p>		<p>52. Name of informant: <u>John Doe</u></p>	
<p>53. Name of informant: <u>John Doe</u></p>		<p>54. Name of informant: <u>John Doe</u></p>	
<p>55. Name of informant: <u>John Doe</u></p>		<p>56. Name of informant: <u>John Doe</u></p>	
<p>57. Name of informant: <u>John Doe</u></p>		<p>58. Name of informant: <u>John Doe</u></p>	
<p>59. Name of informant: <u>John Doe</u></p>		<p>60. Name of informant: <u>John Doe</u></p>	
<p>61. Name of informant: <u>John Doe</u></p>		<p>62. Name of informant: <u>John Doe</u></p>	
<p>63. Name of informant: <u>John Doe</u></p>		<p>64. Name of informant: <u>John Doe</u></p>	
<p>65. Name of informant: <u>John Doe</u></p>		<p>66. Name of informant: <u>John Doe</u></p>	
<p>67. Name of informant: <u>John Doe</u></p>		<p>68. Name of informant: <u>John Doe</u></p>	
<p>69. Name of informant: <u>John Doe</u></p>		<p>70. Name of informant: <u>John Doe</u></p>	
<p>71. Name of informant: <u>John Doe</u></p>		<p>72. Name of informant: <u>John Doe</u></p>	
<p>73. Name of informant: <u>John Doe</u></p>		<p>74. Name of informant: <u>John Doe</u></p>	
<p>75. Name of informant: <u>John Doe</u></p>		<p>76. Name of informant: <u>John Doe</u></p>	
<p>77. Name of informant: <u>John Doe</u></p>		<p>78. Name of informant: <u>John Doe</u></p>	
<p>79. Name of informant: <u>John Doe</u></p>		<p>80. Name of informant: <u>John Doe</u></p>	
<p>81. Name of informant: <u>John Doe</u></p>		<p>82. Name of informant: <u>John Doe</u></p>	
<p>83. Name of informant: <u>John Doe</u></p>		<p>84. Name of informant: <u>John Doe</u></p>	
<p>85. Name of informant: <u>John Doe</u></p>		<p>86. Name of informant: <u>John Doe</u></p>	
<p>87. Name of informant: <u>John Doe</u></p>		<p>88. Name of informant: <u>John Doe</u></p>	
<p>89. Name of informant: <u>John Doe</u></p>		<p>90. Name of informant: <u>John Doe</u></p>	
<p>91. Name of informant: <u>John Doe</u></p>		<p>92. Name of informant: <u>John Doe</u></p>	
<p>93. Name of informant: <u>John Doe</u></p>		<p>94. Name of informant: <u>John Doe</u></p>	
<p>95. Name of informant: <u>John Doe</u></p>		<p>96. Name of informant: <u>John Doe</u></p>	
<p>97. Name of informant: <u>John Doe</u></p>		<p>98. Name of informant: <u>John Doe</u></p>	
<p>99. Name of informant: <u>John Doe</u></p>		<p>100. Name of informant: <u>John Doe</u></p>	

FOR STATE  
HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2/57

7551

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07698

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DUNDALK</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>53 DUNDALK</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>7308 SCHOOL AVE</b>				d. STREET ADDRESS <b>7308 SCHOOL AVE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>GEORGE STRAUSS</b>				4. DATE OF DEATH Month Day Year <b>JULY 12 19 59</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB 26, 1889</b>		9. AGE (In years last birthday) <b>70 yrs.</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLERK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RAILROAD</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHRISTIAN STRAUSS</b>				14. MOTHER'S MAIDEN NAME <b>ANNA M. AULL</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>717-07-7654</b>		17. INFORMANT Address <b>MRS PERTHA KELLER 9307 MARTELL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>A-S-C-U DISEASE</b> (a), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED White <input checked="" type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>M. B. Davis</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>M. B. DAVIS MD</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7/15/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>MORELAND PARK</b>		22d. LOCATION (City, town, or county) (State) <b>PARKVILLE MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>ULLRICH FUNERAL HOME-DUNDALK MD</b>				24a. REC'D BY REGISTRAR <b>DATE JUL 14 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Catharina E. Hanna</b>	

MEDICAL CERTIFICATION

2





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7716

## CERTIFICATE OF DEATH

07699

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto. 7</u>	c. LENGTH OF STAY IN 1b <u>1 week</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick 1</u> 10X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>His daughter's home 3411 Fairview Ave Balto 7</u>		d. STREET ADDRESS <u>R.F.D 7, Frederick, Md</u>	
3. NAME OF DECEASED (Type or print) <u>Charles B. Streett</u>		4. DATE OF DEATH <u>Sat July 25 1959</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> <u>NEVER MARRIED</u> <input type="checkbox"/> <u>WIDOWED</u> <input type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 28, 1880</u> 78 yrs.
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Painting</u>	
11. BIRTHPLACE (State or foreign country) <u>Harford Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Streett</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Blaine</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>Mrs Blanche A Streett RFD 7, Frederick Md</u>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Prostate</u> DUE TO <u>With metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Arterio-sclerosis &amp; Metastases</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 1959</u> to <u>July 25, 1959</u> that I last saw the deceased alive on <u>July 25, 1959</u> , and that death occurred at <u>5:46</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M Paul Byers</u> M.D.		DATE SIGNED <u>Jul 30 1959</u>	
PHYSICIAN'S NAME (Type) <u>M Paul Byers</u>		<u>Balto 14 Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>7/28/59</u>	<u>Moreland Memorial</u>	<u>Balto. Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Loring Byers</u>		24a. REC'D BY REGISTRAR <u>Jul 30 '59</u>	
ADDRESS <u>8738 Liberty Rd Randallstown, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>	



7717

## CERTIFICATE OF DEATH

Reg. Dist. No.

07700

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>3 Y 01 - 4</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in the Pines-16 Fusting Ave.</u>				d. STREET ADDRESS <u>4 Upland Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>LAURA</u> Middle <u>A.</u> Last <u>SUMMERS</u>				4. DATE OF DEATH Month <u>July</u> Day <u>7</u> Year <u>1959</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 30, 1875</u>		9. AGE (In years lost birthday) <u>83</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>---</u>	
13. FATHER'S NAME <u>Samuel Burrows</u>				14. MOTHER'S MAIDEN NAME <u>Martha -</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>---</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>Mrs. E. Mae Maser - 4 Upland Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Decompensation</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chs. Hypertension Cardio-Vascular Diseases</u> DUE TO (c) <u>---</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u> <u>10 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-29, 1959</u> , to <u>7-7-, 1959</u> , that I last saw the deceased alive on <u>7-7-, 1959</u> , and that death occurred at <u>12:05 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wilmer K. Gallager</u>				ADDRESS (Street, city or town, state) <u>6209 Frederick Ave. Baltimore - 28, Md.</u>		DATE SIGNED <u>7-7-59</u>	
PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallager</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/10/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>London Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. 29, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Dickerson &amp; Sons - Balto 17</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 13 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7718

# CERTIFICATE OF DEATH

07701

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 CATONSVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HOUSE IN THE PINES</u>		d. STREET ADDRESS <u>619 LONGVIEW RD.</u>	
3. NAME OF DECEASED (Type or print) <u>GEORGE ASHTON SUTHERLAND JR.</u>		4. DATE OF DEATH <u>JULY 12, 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 4, 1884</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>1ST NAT. BANK</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>GEORGE A. SUTHERLAND</u>		14. MOTHER'S MAIDEN NAME <u>SUSAN BAKER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <u>217-14-1171</u>	
17. INFORMANT <u>MR. ROBERT B. SUTHERLAND</u>		Address <u>619 LONGVIEW DR.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>RT SIDED CARDIAC FAILURE</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis</u> (c) <u>myocard</u> INTERVAL BETWEEN ONSET AND DEATH <u>14 July 1959</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/23</u> , 19 <u>58</u> , to <u>6/12</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6/11</u> , 19 <u>59</u> , and that death occurred at <u>6:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Cliff Ratliff Jr.</u> M.D.		<u>4605 Ed. Norris Ave.</u>	
PHYSICIAN'S NAME (Type) <u>CLIFF RATLIFF JR.</u>		<u>Ball 29, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>JULY 15, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>GREENMOUNT CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>WITKE FUNERAL DIR. 4101 EDMONDSON AVE.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 14 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

10301

CERTIFICATE OF BIRTH

1917

MASSACHUSETTS

MASSACHUSETTS

10301



TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 5  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7719

## CERTIFICATE OF DEATH

07702

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4234 Milford Mill Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>W. Charlton</b> Middle <b>Talbott</b> Last <b></b>		4. DATE OF DEATH Month <b>July</b> Day <b>1</b> Year <b>1959</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/23/1913</b>
9. AGE (In years last birthday) yrs. <b>46</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stationary Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Childrens Hosp.</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William C. Talbott</b>		14. MOTHER'S MAIDEN NAME <b>Elvia Ryan</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>215-05-5687</b>	
17. INFORMANT <b>Jean E. Talbott</b>		Address <b>4234 Milford Mill Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion with Myocardial Infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Arteriosclerosis</b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 10</b> , 19 <b>58</b> , to <b>July 1</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>June 16</b> , 19 <b>59</b> , and that death occurred at <b>2 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1014 St Paul St</b> DATE SIGNED <b>Balt 2, Md</b>			
ACTUAL SIGNATURE <b>J. Frank Supplee, III</b> M.D.			
PHYSICIAN'S NAME (Type) <b>J. Frank Supplee, III</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7/4/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John T. Stansbury</b>		ADDRESS <b>6411 Windsor Mill Rd.</b>	
24a. REC'D BY REGISTRAR DATE <b>JUL 6 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

10

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7720

## CERTIFICATE OF DEATH

07704

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>D.C. Maryland</b> b. COUNTY <b>Prince George</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>	c. LENGTH OF STAY IN 1b <b>23yr5mth8dys</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D. C.</b> <b>47X-3</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Herbert</b> Middle <b>Taylor</b> Last <b>Taylor</b>		4. DATE OF DEATH Month <b>July</b> Day <b>23</b> Year <b>19 59</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 18, 1895</b>
9. AGE (In years last birthday) <b>63</b> yrs.		10. IF UNDER 1 YEAR Months <b>63</b> Days <b>0</b> Hours <b>0</b> Min.	11. IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Virginia</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>W. S. Taylor</b>		14. MOTHER'S MAIDEN NAME <b>Maryl Olndorff</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lymphosarcomatosis, generalized</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>200.1</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 10</b> , 19 <b>59</b> to <b>July 23</b> , 19 <b>59</b> that I last saw the deceased alive on <b>July 23</b> , 19 <b>59</b> , and that death occurred at <b>8:40a</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>7-23-59</b> ACTUAL SIGNATURE <b>Stella Wachslar</b> M.D. <b>Stella Wachslar, M. D.</b> <b>Catonsville 28, Maryland</b> PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-25-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Wash. D.C.</b>		22d. LOCATION (City, town, or county) (State) <b>Wash. D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. G. Matteringly</b>		24a. REC'D BY REGISTRAR <b>JUL 27 59</b>	
ADDRESS <b>131- 11th St. S.E.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Evans</b>	

063507

4 44444 3 0116

## 7721 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hoxleigh Convalescent Home</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>BENJAMIN</u> First <u>STUART</u> Middle <u>TONGUE</u> Last				4. DATE OF DEATH <u>July</u> Month <u>13</u> Day <u>1959</u> Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 27, 1896</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months <u>62</u> Days <u>62</u> Hours <u>62</u> Min.		IF UNDER 24 HRS. Months <u>62</u> Days <u>62</u> Hours <u>62</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance Broker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Thomas T. Tongue</u>				14. MOTHER'S MAIDEN NAME <u>Mary Van Ardale</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>WWI</u>				16. SOCIAL SECURITY NO. <u>WWI</u>		17. INFORMANT <u>Mrs Margaret Dodd Tongue</u> Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO <u>Generalized Arterio-sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arterio-sclerosis</u> DUE TO (c) <u>7 phlog.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>April</u> , 1954, to <u>July 13</u> , 1959, that I last saw the deceased alive on <u>July 13</u> , 1959, and that death occurred at <u>6:15 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Warde B. Allan M.D.</u>				ADDRESS (Street, city or town, state) <u>6 E. Eager St. Balto.</u> DATE SIGNED <u>7/10/59</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Warde B. Allan</u> , <u>6 E. Eager St., Baltimore 2, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 15, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville, Balto., Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sherry W. Jenkins &amp; Sons Co.</u> ADDRESS <u>4905 York Rd</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 15 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Date of registration	
13. Name of registrar		14. Name of informant		15. Name of physician	
16. Name of hospital		17. Name of doctor		18. Name of nurse	
19. Name of family		20. Name of friends		21. Name of neighbors	
22. Name of community		23. Name of country		24. Name of state	
25. Name of union		26. Name of world		27. Name of universe	
28. Name of everything		29. Name of nothing		30. Name of everything and nothing	



7722

## CERTIFICATE OF DEATH

07706

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PIKESVILLE</u>				c. LENGTH OF STAY IN 1b <u>8 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>17 HAWTHORNE AVE.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>NORMAN SAMUEL VALENTINE</u>				4. DATE OF DEATH Month <u>7</u> Day <u>26</u> Year <u>1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT 29 - 1902</u>	
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRACTOR TRAILER OPER. JAMES GIBBONS DETOUR MARYLAND</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S.A.</u>			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>HARVEY EDGAR VALENTINE</u>				14. MOTHER'S MAIDEN NAME <u>ADIE B. TROXELL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>213-016-310</u>			
17. INFORMANT <u>Mrs. ADELINE M. VALENTINE</u>				Address <u>17 Hawthorne</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Colon with Metastasis</u> 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>March</u> , 1957, to <u>July 26</u> , 1959, that I lost saw the deceased alive on <u>July 23</u> , 1959, and that death occurred at <u>8:42 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James G. Miller</u>				ADDRESS (Street, city or town, state) <u>1331 Reisterstown Rd., Pikesville, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Frank H. Newell - Pikesville, Maryland</u>				DATE SIGNED <u>7/27/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7-29-59</u>		<u>EVERGREEN MEMORIAL</u>		<u>Finksburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell - Pikesville, Maryland</u>				24a. REC'D BY REGISTRAR <u>JUL 29 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Hume</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7723 CERTIFICATE OF DEATH

Reg. Dist. No.

07707

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>3yr5mth16dys</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pisgah, Maryland</u>		d. STREET ADDRESS <u>08X-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>M.</u> Last <u>Vanderslice</u>		4. DATE OF DEATH Month <u>July</u> Day <u>11</u> Year <u>1959</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 15, 1879</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William Vanderslice</u>		14. MOTHER'S MAIDEN NAME <u>Cecelia Mattie</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Decompensatory heartdisease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive heart failure</u> DUE TO (c) <u>Arteriosclerotic cardiovascular disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>months</u> <u>years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> Month <u>  </u> Day <u>  </u> Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 6, 1959</u> , to <u>7-11-1959</u> , that I last saw the deceased alive on <u>July 11, 1959</u> , and that death occurred at <u>1035 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. Simopoulos</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>SPRING GROVE STATE HOSPITAL</u> <u>7-12-59</u>	
PHYSICIAN'S NAME (Type) <u>ARISTIDES M. SIMOPOULOS</u>		<u>Catonsville 28, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>15 JULY '59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cen</u>	22d. LOCATION (City, town, or county) (State) <u>Wash. DC</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home</u>		ADDRESS <u>44 Manassas NE</u>	
24a. REC'D BY REGISTRAR DATE <u>JUL 14 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Cirino S. Thomas</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7724 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **07708**

**FOR STATE HEALTH DEPT.**

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>instant</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Joppa, Rural, R.D. # 1 Box 336 / 2x-2</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <b>Clayton Rd.,</b>			
3. NAME OF DECEASED (Type or print) First <b>Paul</b> Middle <b>Sylvester</b> Last <b>Vanorsdale</b>				4. DATE OF DEATH Month <b>July</b> Day <b>19</b> Year <b>19 59</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 3, 1929</b>		9. AGE (In years last birthday) <b>29</b> yrs.	IF UNDER 1 YEAR Months <b>1</b> Days <b>19</b> Hours <b>59</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home Repairs</b>		11. BIRTHPLACE (State or foreign country) <b>Akron, Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.,</b>	
13. FATHER'S NAME <b>Elmer Vanorsdale</b>				14. MOTHER'S MAIDEN NAME <b>Wisner</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>236-42-2331</b>		17. INFORMANT Address <b>Mary L. Vanorsdale, Joppa, Maryland.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fractured Neck - Crushing</b> 823X DUE TO (b) <b>Injury of Chest Probable</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>Fractured Skull</b> INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Driving Automobile which Struck Steel Utility Pole</b>					
20c. TIME OF INJURY Hour <b>4</b> o. m. <b>7/19/1959</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>State Road</b>		20f. (City or town) <b>Towson</b>		(County) <b>Balto.,</b> (State) <b>Maryland</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Charles F O'Donnell</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Charles F O'Donnell</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/21/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Memorial Gardens</b>		22d. LOCATION (City, town, or county) (State) <b>Bel Air Harford Md.,</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward R. McCombs Jr</b>				ADDRESS <b>Abingdon, Md.,</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 23 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





7725

## CERTIFICATE OF DEATH

Reg. Dist. No.

07709

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Pikesville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1505 Lightfoot Drive</u>		d. STREET ADDRESS <u>1505 Lightfoot Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Oscar</u> First <u>Wasserman</u> Middle <u>Wasserman</u> Last		4. DATE OF DEATH <u>7-8-1959</u> Month <u>7</u> Day <u>8</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>meat</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Morris Wasserman</u>	
14. MOTHER'S MAIDEN NAME <u>Bessie</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	
16. SOCIAL SECURITY NO. <u>INFORMANT</u>		Address <u>Anne Wasserman - Anne</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertension and Hypertensive Cardio-vascular disease.</u> DUE TO <u>443X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Thrombosis of Basilar Artery and</u> DUE TO <u>Stroke. (Cerebro-vascular accident)</u> (c) <u>2 days.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>years.</u> <u>3 month.</u> <u>2 days.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 2, 1959</u> to <u>July 8, 1959</u> , that I last saw the deceased alive on <u>July 8, 1959</u> , and that death occurred at <u>7:07 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. Golpira</u>		ADDRESS (Street, city or town, state) <u>4215 Park Heights Ave. #15</u>	
PHYSICIAN'S NAME (Type) <u>Dr. A. GOLPIRA</u>		DATE SIGNED <u>July 8, 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>7-9-59</u>	<u>Rosedale</u>	<u>Balto Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis</u>		ADDRESS <u>2100 Eutan Pl</u>	
24a. REC'D BY REGISTRAR <u>DAHL 1 0 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. K...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

17308

CERTIFICATE OF DEATH

17308

X

1

7726

## CERTIFICATE OF DEATH

Reg. Dist. No. 07710

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Carney</u>				c. LENGTH OF STAY IN 1b <u>4 months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3407 Orbitan Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Anna L Webb</u>				4. DATE OF DEATH Month Day Year <u>July 18 / 59</u> 19			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 9 1900</u>	9. AGE (In years last birthday) <u>58</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Frederick J Eckert</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Felter</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>No.</u>		16. SOCIAL SECURITY NO. <u>Informant</u>		Address <u>Mrs Kathryn Cuomo 3939 Lyndale Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>5 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 6</u> , 1959, to <u>July 15</u> , 1959, that I last saw the deceased alive on <u>July 18</u> , 1959, and that death occurred at <u>3</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>3601 Greenway Baltimore</u> <u>2039</u>							
ACTUAL SIGNATURE <u>Stephen J Van Lell III</u>		M.D. <u>3601 Greenway Baltimore</u>		PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>July 22/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Ullrich Funeral Home 4210 Belair Road.</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

01310

7325

01310

01310

*[Faint, illegible text and markings, possibly bleed-through from the reverse side of the page. Some faint words like "RECEIVED" and "OFFICE" are visible.]*

## 7727 CERTIFICATE OF DEATH

07711

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6. S. Beechwood Ave.</u>		e. STREET ADDRESS <u>16 S. Beechwood Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Robert James Webb</u> First Middle Last		4. DATE OF DEATH Month <u>7</u> Day <u>1</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/9/73</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. mail</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carrier</u>	11. BIRTHPLACE (State or foreign country) <u>Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Philip Webb</u>	
14. MOTHER'S MAIDEN NAME <u>Powell</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>Edith Webb</u>		INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO <u>Cardio-Vascular Disease &amp; General</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-Sclerosis Medial</u> (c) <u>Arterio-Sclerosis Medial</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>1957</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>11/10</u> , 19 <u>49</u> , to <u>7/1</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6/30</u> , 19 <u>59</u> , and that death occurred at <u>2:05 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edith W. Johnson</u> M.D.		ADDRESS (Street, city or town, state) <u>3432 Frederick Ave</u> DATE SIGNED <u>7/2/59</u>	
PHYSICIAN'S NAME (Type) <u>Balt more 29 Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>7/4/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>	22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mac Webb + Son</u> ADDRESS <u>28</u>		24a. REC'D BY REGISTRAR <u>JUL 6 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]*



7728

CERTIFICATE OF DEATH

Reg. Dist. No.

07712

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>9 yrs</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>52 Catonsville</b>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1917 Rolling Glen Road</b>				d. STREET ADDRESS <b>1917 Rolling Glen Road</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Alois Weimer</b> First Middle Last				4. DATE OF DEATH <b>July 16/59</b> Month Day Year			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 5, 1889</b>		9. AGE (In years lost birthday) <b>70</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Owner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Weimer Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>---Weimer</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>217 32 8542</b>		INFORMANT <b>Mrs. Margarite Weimer, 1917 Rolling Glen Road</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction, acute</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 16, 1959</b> , to <b>July 16, 1959</b> , that I last saw the deceased alive on <b>July 16, 1959</b> , and that death occurred at <b>4:00 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Theodore T. Niznik M.D.</b>				PHYSICIAN'S NAME (Type) <b>THEODORE T. NIZNIK M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 20/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore 7, Md.</b>	
23a. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke Funeral Directors, 4101 Edmondson Ave</b>				23b. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
				DATE <b>JUL 21 '59</b>		<b>Carlton S. Hanna</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

01210

CONFIDENTIAL

1722

Bellevue

10

Bellevue

Bellevue

10

Bellevue

xx

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

10

Bellevue

x

Bellevue

USA

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

10

Bellevue

10

10

10

10

10

10

10

10

10

10

10

10

10

10

7729

## CERTIFICATE OF DEATH

Reg. Dist. No.

07713

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 12		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 12	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1301 Glendale Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Harold David Melsh Welch</u>		4. DATE OF DEATH Month Day Year <u>7-13-1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 11, 1895</u>
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gas &amp; Elec. Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry Melsh Welch</u>		14. MOTHER'S MAIDEN NAME <u>Nellie Mac Intire</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Helen Welsh 1301 Glendale Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c) <u>DIABETES MELLITUS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Months</u> <u>&gt; 15 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>November</u> , 1958, to <u>July</u> , 1959, that I last saw the deceased alive on <u>July 13</u> , 1959, and that death occurred at <u>11:55 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Albert B. Bradley</u> M.D.		ADDRESS (Street, city or town, state) <u>4900 Belair Road Balto. 6 Md</u> DATE SIGNED <u>7/14/59</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Albert B. Bradley</u>		<u>4900 Belair Rd. Balto. 6, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-17-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road</u>		24a. REC'D BY REGISTRAR <u>JUL 16 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. The first part of the report is a general description of the project. It includes the title, the objectives, the scope, and the organization of the project. The title is "The Effect of Temperature on the Rate of Reaction of Hydrogen Peroxide with Potassium Iodate". The objectives are to determine the effect of temperature on the rate of reaction and to determine the activation energy of the reaction. The scope is to study the reaction of hydrogen peroxide with potassium iodate at different temperatures. The organization of the project is as follows: a general description of the project, a description of the experimental procedure, a description of the results, and a conclusion.

2. The second part of the report is a description of the experimental procedure. It includes the materials, the apparatus, and the procedure. The materials are hydrogen peroxide, potassium iodate, and sulfuric acid. The apparatus is a conical flask, a stopper, a thermometer, and a water bath. The procedure is as follows: a solution of potassium iodate is prepared in a conical flask. A solution of hydrogen peroxide is added to the flask. The flask is placed in a water bath at a certain temperature. The reaction is allowed to proceed for a certain time. The rate of reaction is determined by measuring the volume of oxygen gas evolved.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

7730

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07714

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN TB <b>32 yrs.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>55 Towson</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Providence Road</b>		/d. STREET ADDRESS <b>Providence Road</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>FRANK</b> Middle <b>WERNIK</b> Last <b>WERNIK</b>		4. DATE OF DEATH Month <b>July</b> Day <b>18</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 22, 1876</b>
9. AGE (In years last birthday) <b>82 yrs.</b>		IF UNDER 1 YEAR Months <b>82</b> Days <b>18</b> Hours <b>19</b> Min. <b>59</b>	IF UNDER 24 HRS. Months <b>82</b> Days <b>18</b> Hours <b>19</b> Min. <b>59</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self-employed</b>	11. BIRTHPLACE (State or foreign country) <b>Poland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>?</b>		14. MOTHER'S MAIDEN NAME <b>?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Frances Karwacki, 3625 Echodale Ave</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c) <b>DUE TO</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>19</b> o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>R. S. FISHER</b>		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>R. S. FISHER</b>		DATE SIGNED <b>7-19-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/22/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Holy Rosary</b>		22d. LOCATION (City or town) (County) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. F. SADOWSKI &amp; SONS, 1808 EASTERN AVE</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 22 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7731 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07715

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MD</b> b. COUNTY <b>BALTO.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OWINGS MILLS</b>		c. LENGTH OF STAY IN 1b <b>18 YRS 5MO.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OWINGS MILLS</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ROSEWOOD STATE TRAINING SCHOOL</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LAMAR</b> Middle <b>WIGGER</b> Last <b>WIGGER</b>				4. DATE OF DEATH Month <b>JULY</b> Day <b>28</b> Year <b>1959</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>NOV. 26, 1933</b>		9. AGE (In years last birthday) <b>25</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>WILLIAM HENRY WIGGER</b>				14. MOTHER'S MAIDEN NAME <b>CARMELA ROSE BROCATO</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>ROSEWOOD RECORDS</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>STRANGULATION</b> <b>795.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>MASSIVE ASPIRATION OF STOMACH CONTENTS</b> DUE TO (c) <b>10 MIN.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>5 MIN.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>NONE</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>NONE</b>					
20c. TIME OF INJURY Hour o. m. p. m. <b>NONE</b>	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>NONE</b>	20f. (City or town) <b>NONE</b>	(County)	(State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Martin E. Strobel</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>7/28/59</b>	
EXAMINER'S NAME (Type) <b>Martin E. Strobel</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>July 31/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rosewood Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Owings Mills Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.F.Eline &amp; Sons Reisterstown, Md.</b>				24a. REC'D BY REGISTRAR <b>AUG 31 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

1

1

1

1

1

07715

STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF NEW YORK

Form with multiple sections for medical examination, including fields for name, date, time, place, and cause of death. The form is oriented horizontally but contains vertical text columns.

1  
M  
090  
1  
0  
TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 77 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7732

## CERTIFICATE OF DEATH

Reg. Dist. No.

07716

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COCKEYSVILLE</b>		c. LENGTH OF STAY IN 1b <b>4 MONTHS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MASONIC HOME</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARY BEAVER WOLFE</b>		4. DATE OF DEATH Month Day Year <b>JULY 29 1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/24/1877</b>
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>PENNSYLVANIA</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S</b>	
13. FATHER'S NAME <b>WILLIAM BEAVER</b>		14. MOTHER'S MAIDEN NAME <b>SUSAN HALL</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>NONE</b>	
17. INFORMANT <b>Frank R. Smith Jr.</b>		Address <b>Cockeysville</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO <b>Arterio Sclerotic Cardio Vascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4/1</b> , 1959, to <b>7/29</b> , 1959, that I last saw the deceased alive on <b>7/24</b> , 1959, and that death occurred at <b>7:28 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cockeysville, Md</b> DATE SIGNED <b>7/29/59</b>			
ACTUAL SIGNATURE <b>Walter T. Kees</b>		M.D. <b>Cockeysville, Md</b>	
PHYSICIAN'S NAME (Type) <b>Walter T. Kees</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>8-1-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Woodland, Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc., 1217 St. Paul Street</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 31 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knaus</b>	

# CERTIFICATE OF DEATH

1933

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Jan 15 1933</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>		9. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>	
10. SIGNATURE OF REGISTRAR <i>John Doe</i>		11. SIGNATURE OF WITNESS <i>John Doe</i>		12. SIGNATURE OF WITNESS <i>John Doe</i>	
13. SIGNATURE OF WITNESS <i>John Doe</i>		14. SIGNATURE OF WITNESS <i>John Doe</i>		15. SIGNATURE OF WITNESS <i>John Doe</i>	
16. SIGNATURE OF WITNESS <i>John Doe</i>		17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF WITNESS <i>John Doe</i>	
19. SIGNATURE OF WITNESS <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>John Doe</i>		21. SIGNATURE OF WITNESS <i>John Doe</i>	
22. SIGNATURE OF WITNESS <i>John Doe</i>		23. SIGNATURE OF WITNESS <i>John Doe</i>		24. SIGNATURE OF WITNESS <i>John Doe</i>	
25. SIGNATURE OF WITNESS <i>John Doe</i>		26. SIGNATURE OF WITNESS <i>John Doe</i>		27. SIGNATURE OF WITNESS <i>John Doe</i>	
28. SIGNATURE OF WITNESS <i>John Doe</i>		29. SIGNATURE OF WITNESS <i>John Doe</i>		30. SIGNATURE OF WITNESS <i>John Doe</i>	
31. SIGNATURE OF WITNESS <i>John Doe</i>		32. SIGNATURE OF WITNESS <i>John Doe</i>		33. SIGNATURE OF WITNESS <i>John Doe</i>	
34. SIGNATURE OF WITNESS <i>John Doe</i>		35. SIGNATURE OF WITNESS <i>John Doe</i>		36. SIGNATURE OF WITNESS <i>John Doe</i>	
37. SIGNATURE OF WITNESS <i>John Doe</i>		38. SIGNATURE OF WITNESS <i>John Doe</i>		39. SIGNATURE OF WITNESS <i>John Doe</i>	
40. SIGNATURE OF WITNESS <i>John Doe</i>		41. SIGNATURE OF WITNESS <i>John Doe</i>		42. SIGNATURE OF WITNESS <i>John Doe</i>	
43. SIGNATURE OF WITNESS <i>John Doe</i>		44. SIGNATURE OF WITNESS <i>John Doe</i>		45. SIGNATURE OF WITNESS <i>John Doe</i>	
46. SIGNATURE OF WITNESS <i>John Doe</i>		47. SIGNATURE OF WITNESS <i>John Doe</i>		48. SIGNATURE OF WITNESS <i>John Doe</i>	
49. SIGNATURE OF WITNESS <i>John Doe</i>		50. SIGNATURE OF WITNESS <i>John Doe</i>		51. SIGNATURE OF WITNESS <i>John Doe</i>	
52. SIGNATURE OF WITNESS <i>John Doe</i>		53. SIGNATURE OF WITNESS <i>John Doe</i>		54. SIGNATURE OF WITNESS <i>John Doe</i>	
55. SIGNATURE OF WITNESS <i>John Doe</i>		56. SIGNATURE OF WITNESS <i>John Doe</i>		57. SIGNATURE OF WITNESS <i>John Doe</i>	
58. SIGNATURE OF WITNESS <i>John Doe</i>		59. SIGNATURE OF WITNESS <i>John Doe</i>		60. SIGNATURE OF WITNESS <i>John Doe</i>	
61. SIGNATURE OF WITNESS <i>John Doe</i>		62. SIGNATURE OF WITNESS <i>John Doe</i>		63. SIGNATURE OF WITNESS <i>John Doe</i>	
64. SIGNATURE OF WITNESS <i>John Doe</i>		65. SIGNATURE OF WITNESS <i>John Doe</i>		66. SIGNATURE OF WITNESS <i>John Doe</i>	
67. SIGNATURE OF WITNESS <i>John Doe</i>		68. SIGNATURE OF WITNESS <i>John Doe</i>		69. SIGNATURE OF WITNESS <i>John Doe</i>	
70. SIGNATURE OF WITNESS <i>John Doe</i>		71. SIGNATURE OF WITNESS <i>John Doe</i>		72. SIGNATURE OF WITNESS <i>John Doe</i>	
73. SIGNATURE OF WITNESS <i>John Doe</i>		74. SIGNATURE OF WITNESS <i>John Doe</i>		75. SIGNATURE OF WITNESS <i>John Doe</i>	
76. SIGNATURE OF WITNESS <i>John Doe</i>		77. SIGNATURE OF WITNESS <i>John Doe</i>		78. SIGNATURE OF WITNESS <i>John Doe</i>	
79. SIGNATURE OF WITNESS <i>John Doe</i>		80. SIGNATURE OF WITNESS <i>John Doe</i>		81. SIGNATURE OF WITNESS <i>John Doe</i>	
82. SIGNATURE OF WITNESS <i>John Doe</i>		83. SIGNATURE OF WITNESS <i>John Doe</i>		84. SIGNATURE OF WITNESS <i>John Doe</i>	
85. SIGNATURE OF WITNESS <i>John Doe</i>		86. SIGNATURE OF WITNESS <i>John Doe</i>		87. SIGNATURE OF WITNESS <i>John Doe</i>	
88. SIGNATURE OF WITNESS <i>John Doe</i>		89. SIGNATURE OF WITNESS <i>John Doe</i>		90. SIGNATURE OF WITNESS <i>John Doe</i>	
91. SIGNATURE OF WITNESS <i>John Doe</i>		92. SIGNATURE OF WITNESS <i>John Doe</i>		93. SIGNATURE OF WITNESS <i>John Doe</i>	
94. SIGNATURE OF WITNESS <i>John Doe</i>		95. SIGNATURE OF WITNESS <i>John Doe</i>		96. SIGNATURE OF WITNESS <i>John Doe</i>	
97. SIGNATURE OF WITNESS <i>John Doe</i>		98. SIGNATURE OF WITNESS <i>John Doe</i>		99. SIGNATURE OF WITNESS <i>John Doe</i>	
100. SIGNATURE OF WITNESS <i>John Doe</i>		101. SIGNATURE OF WITNESS <i>John Doe</i>		102. SIGNATURE OF WITNESS <i>John Doe</i>	

RECEIVED

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT THIS CERTIFICATE IS CORRECTLY FILLED OUT AND THAT THE SIGNATURES ARE PROPERLY VERIFIED. ANY FALSIFICATION OF THIS CERTIFICATE IS A CRIME UNDER THE LAWS OF THE STATE OF MARYLAND.

7733

## CERTIFICATE OF DEATH

07717

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>				c. LENGTH OF STAY IN TB			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Codd Nursing Home</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sunnybrook</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS <b>Jarrettsville Pike</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>HELEN ALICE WOOD</b>				4. DATE OF DEATH Month Day Year <b>July 6, 1959</b> 19			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>June 7, 1903</b>		9. AGE (In years last birthday) <b>56</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert H. Ruhl</b>				14. MOTHER'S MAIDEN NAME <b>Annie Lee</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>Family records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b> <b>331x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>Arteriosclerosis</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>1 1/4 yrs</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 13, 1958</b> , to <b>July 7, 1959</b> , that I last saw the deceased alive on <b>June 30, 1959</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>J. Frank Supplee, III</b>				ADDRESS (Street, city or town, state) <b>1014 St Paul St, Balt 2, Md.</b>			
PHYSICIAN'S NAME (Type) <b>J. Frank Supplee, III</b>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 10, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fairview Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Sunnybrook, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns' Sons, Towson, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 13 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Baltimore

Towson

John William Jones

WHITE ALICE WOOD

Jamesville 1884

July 1, 1900

Female

June 1, 1900

26

Married

Own home

Resident

Robert H. Jones

Annie Lee

None

Family records

July 10, 1900

Towson, Maryland

John Jones, Son, Towson, Maryland



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

7552

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07718

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>53 Dundalk</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>720 S. 51st Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARGARET</b> Middle <b>YINGLING</b> Last <b>POPP</b>		4. DATE OF DEATH Month <b>July</b> Day <b>30</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>	8. DATE OF BIRTH <b>December 8, 1883</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Albert E. Glaser</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Popp</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>George H. Yingling 720 S. 51st Street-22</b>	
17. INFORMANT <b>George H. Yingling 720 S. 51st Street-22</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> <b>420.0</b> DUE TO Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) <b>Generalized Arteriosclerosis</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b> <b>20 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>JACK C COLLINS</b>		DATE SIGNED <b>7-30-59</b>	
EXAMINER'S NAME (Type) <b>JACK C COLLINS</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Aug. 1, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ullrich Funeral Home Dundalk, Md.</b>		24a. REC'D BY REGISTRAR <b>Aug 3 '59</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION

1

2

1. Name of patient  
2. Address  
3. Date of birth  
4. Sex  
5. Race  
6. Religion  
7. Education  
8. Occupation  
9. Marital status  
10. Social history  
11. Family history  
12. Present illness  
13. Past medical history  
14. Allergies  
15. Current medications  
16. Physical examination  
17. Laboratory tests  
18. Imaging studies  
19. Pathology  
20. Treatment  
21. Prognosis  
22. Follow-up

1552

MARYLAND STATE DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of patient		2. Address	
3. Date of birth		4. Sex	
5. Race		6. Religion	
7. Education		8. Occupation	
9. Marital status		10. Social history	
11. Family history		12. Present illness	
13. Past medical history		14. Allergies	
15. Current medications		16. Physical examination	
17. Laboratory tests		18. Imaging studies	
19. Pathology		20. Treatment	
21. Prognosis		22. Follow-up	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7734 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07719

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrison</u> c. LENGTH OF STAY IN 1b <u>15 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montrose Ave.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Garrison</u> d. STREET ADDRESS <u>/ Montrose Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>YAKIM</u> Middle <u>YOCKOWCKE</u> Last <u>YOCKOWCKE</u> <b>4. DATE OF DEATH</b> Month <u>July</u> Day <u>17</u> Year <u>1959</u>				<b>5. SEX</b> <u>MAle</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>About 1899</u> <b>9. AGE</b> (In years last birthday) <u>59</u> yrs. <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Gardening</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Lawnmower</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>Poland</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>UNKNOWN</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>UNKNOWN</u>				<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u>   If yes, give war or dates of service <u>NO</u> <b>16. SOCIAL SECURITY NO.</b> <u>219-16-6382</u> <b>17. INFORMANT</b> <u>William D. Brown</u> , Address <u>107 Delight Rd. Owings Mills.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u> 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>none</u> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u> 20c. TIME OF INJURY Month, Day, Year <u>none</u> 19 <u>none</u> 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <u>none</u> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u> 20f. (City or town) (County) (State) <u>none</u>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b> ACTUAL SIGNATURE <u>D. D. Caples</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <u>D. D. Caples, M. D.</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>7-20-59</u>							
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>7-20-59</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Druid Ridge</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Frank H. Jewell</u>		<b>24a. REC'D BY REGISTRAR</b> DATE <u>JUL 22 '59</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraw</u>			
<b>22d. LOCATION (City, town, or county) (State)</b> <u>Pikesville, Md.</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7735  
CERTIFICATE OF DEATH

Reg. Dist. No.

07720

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>26 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>300 S. Pulaski Street (23)</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED Known: <b>WESLEY</b> First Middle <b>ZIDWICK</b> Last ad: <b>WESLEY</b> <b>ZIDKOWICK</b> (Type or print)		4. DATE OF DEATH Month <b>July</b> Day <b>7</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 15, 1895</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Proprietor - Unemployed Grocery store</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Russia</b>	9. AGE (In years last birthday) yrs. <b>64</b> IF UNDER 1 YEAR Months Days Hours Min.
13. FATHER'S NAME <b>Dimitri Zidkoviak</b>		14. MOTHER'S MAIDEN NAME <b>Sophia Zankovitz</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO. <b>216-32-9259</b>	
17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOGENIC CARCINOMA, RIGHT LUNG, WITH</b> <b>162.1 INDEX GENERALIZED METASTASES</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTERIOSCLEROTIC HEART DISEASE - 10 YEARS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>18 MONTHS</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 11</b> , 19 <b>59</b> , to <b>July 7</b> , 19 <b>59</b> , and that death occurred at <b>11:15 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>John W. Crawford</b> M.D. <b>VAH, FORT HOWARD, MARYLAND</b> <b>7/8/59</b> PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b> <b>VAH, FORT HOWARD, MARYLAND</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/13/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Cowan &amp; Sons</b>		24a. REC'D BY REGISTRAR <b>Hollins &amp; Poppleton</b> <b>Baltimore, Md.</b>	
24b. REGISTRAR'S SIGNATURE <b>Carlton S. Hump</b>		DATE <b>JUL 10 '59</b>	





TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
B  
M  
090

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7736  
CERTIFICATE OF DEATH

07721

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrison</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Foxleigh Nursing Home</u>				d. STREET ADDRESS <u>Marriottsville Rd. Box 368</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>RUSSELL</u> Middle <u>C.</u> Last <u>ZIMMERMAN</u>			4. DATE OF DEATH Month <u>July</u> Day <u>31</u> Year <u>19 59</u>				
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 9, 1906</u>		9. AGE (In years last birthday) <u>52</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Builder - self employed</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William Zimmerman</u>			14. MOTHER'S MAIDEN NAME <u>Blanche Mays</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Mrs. Mary Thelma Zimmerman - Marriottsville Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thromboses</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>Diabetes Mellitus</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>10 yrs.</u> <u>20 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept. 11, 1959</u> to <u>July 31, 1959</u> , that I last saw the deceased alive on <u>July 30, 1959</u> , and that death occurred at <u>11 A.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1810 EUTAW PLACE</u> DATE SIGNED ACTUAL SIGNATURE <u>Herbert Goldstone</u> M.D. PHYSICIAN'S NAME (Type) <u>HERBERT GOLDSTONE M.D.</u> <u>BALTIMORE MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/4/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tiekner Sons - Balt</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>	

